Filing at a Glance

Company:	Security Mutual Life Insurance Company of New York
Product Name:	Applications
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	12/28/2012
SERFF Tr Num:	SMNY-128769403
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	0012950AR 11/2012
Implementation Date Requested:	On Approval
Author(s):	Alana Mautone, Jacqueline Ayres, Derick Deisinger, Gaile Beebe, Catherine Stoehr
Reviewer(s):	Linda Bird (primary)
Disposition Date:	01/04/2013
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Security Mutual Life Insurance Company of New York*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Applications*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Jacqueline Ayres

Status of Filing in Domicile: Authorized
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 01/04/2013
State Status Changed: 01/04/2013
Created By: Jacqueline Ayres
Corresponding Filing Tracking Number:

Filing Description:

Attached for review and approval are the following new individual life application forms and supplemental questionnaires.

0012950AR 11/2012 Application for Individual Life Insurance - Part 1
0013048AR 11/2012 Application for Individual Life Insurance-Part 2-Non-Medical
0013050AR 11/2012 Application for Individual Life Insurance-Part 2-Medical
0013044AR 11/2012 Individual Insurance Application Confidential Financial Statement
0013016AR 11/2012 Conditional receipt
0013046XX 08/2012 Important Notice (MIB & Fair Credit Reporting)
0013029AR 11/2012 Application Supplement for Financed Insurance
0013004AR 11/2012 Aviation Questionnaire
0013010AR 11/2012 Avocation Questionnaire
0013006AR 11/2012 Drug Usage Questionnaire
0013008AR 11/2012 Alcohol Usage Questionnaire
0013014AR 11/2012 Military Questionnaire
0013012AR 11/2012 Foreign Travel/Residence Questionnaire
0012958AR 11/2012 Application for Reinstatement of Individual Life Insurance - Part 1
0013061AR 11/2012 Amendment to Application
0013040AR 11/2012 Statement of Good Health and Insurability
0011832AR 12/2012 Application for Term Conversion
0013071AR 12/2012 Application for Life Insurance Within a Pension or Profit Sharing Plan

When approved, these forms will replace the following previously approved application forms.

IO-4386-AR Ed. 12/97, Application for Individual Life Insurance - Part 1, approved 12/29/97
IO-4372-AR Ed. 12/97 Conditional Receipt, approved 12/29/97
MK-4598-AR Ed. 12/97, Application for Individual Life Insurance-Part 2-Medical, approved 12/30/97
IO-10618-AR Ed. 4/01, Supplemental Application for Preferred or Preferred Plus Risk Classification, approved 5/25/01
0010683XX 02/2009, Important Notice, approved 2/4/09, SERFF Tracking Number SMNY-126007777
MK-10256-AR Ed. 3/98, Confidential Financial Questionnaire, approved 4/7/98
IO-10440-AR Ed. 7/99, Drug Usage Questionnaire, approved 8/11/99
IO-10441-AR Ed. 7/99, Alcohol Usage Questionnaire, approved 8/11/99
IO-10445-AR Ed. 8/99, Avocation Supplement, approved 10/4/99
B-7078, Application for Life Insurance, approved 6/17/65
IO-6916-B-AR Ed. 12/97, Application for Life Insurance - Juvenile, approved 2/10/98

State: *Arkansas* **Filing Company:** *Security Mutual Life Insurance Company of New York*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Applications*
Project Name/Number: */*

MK-5458 Rev. 5/87, Aviation Questionnaire, approved 6/30/87
XX-1134-AR Ed. 1/98, Amendment to Application, approved 1/13/98
IO-10740-AR Ed. 1/03, Application for Life Insurance Within a Pension or Profit Sharing Plan, approved 1/14/03

The above-mentioned applications and associated forms are intended for use with our non-qualified and qualified individual life portfolio, with the exception of 0013071AR 12/2012. 0013071AR 12/2012 is intended for use with our individual life portfolio approved for use in the qualified pension plan market, and in any other Norris type situation. This form may also be used for non-qualified employer-sponsored plans.

These forms will be used as paper and may, in the future, be used telephonically and electronically.

These forms are being changed in part to reflect MIB changes. We are also making changes to gather more information to make it easier to identify and locate beneficiaries. The forms have also been generally updated, as the forms being replaced were several years old.

These forms may be used with the following approved policy forms, as well as other policy forms approved in the future.

2098-U, Flexible Premium Adjustable Universal Life Insurance, approved 5/22/09, SERFF Tracking Number SMNY-125944330
2104, Whole Life Insurance, approved 4/6/10, SERFF Tracking Number SMNY-126443250
2105, Whole Life Insurance Paid Up at 85, approved 4/6/10, SERFF Tracking Number SMNY-126443250

Form 0013047AR 11/2012 Application for Individual Life Insurance-Part 2-Non-Medical and 0013043AR 11/2012 Individual Insurance Application Confidential Financial Statement, are both being filed as stand-alone forms as well as part of 0012950AR 11/2012. An Agent Certification will accompany form 0013047AR 11/2012 and contains the agent replacement questions.

Amendment to Application form 0013060AR 11/2012 will also be used with our approved annuity forms including application form IO-6102-AR Ed. 12/97:

Single Premium Deferred Annuity forms:

2055, 2056, 2055-Q, 2056-Q, approved 7/26/94

Flexible Premium Deferred Annuity forms:

1917-B, approved 2/8/83

Form 0013046XX 11/2012 is exempt from Flesch readability requirements as it was drafted to conform to the requirements of law or regulation.

The forms are submitted in final print and are subject to only minor modification in paper size and stock, ink, border, Company logo and adaption to computer printing.

Please advise if any additional information is required in order to complete your review.

State: *Arkansas* ***Filing Company:*** *Security Mutual Life Insurance Company of New York*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Applications*
Project Name/Number: */*

Company and Contact

Filing Contact Information

Alana Mautone, Senior Product Compliance Analyst amautone@smlny.com
100 Court St.
P. O. Box 1625
Binghamton, NY 13902
607-723-3551 [Phone] 7297 [Ext]
607-338-7562 [FAX]

Filing Company Information

Security Mutual Life Insurance Company of New York
100 Court Street
P. O. Box 1625
Binghamton, NY 13902-1625
(607) 723-3551 ext. 7297[Phone]

CoCode: 68772
Group Code:
Group Name:
FEIN Number: 15-0442730

State of Domicile: New York
Company Type: Life Insurance
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$900.00
Retaliatory?	No
Fee Explanation:	18 forms @$50 = $900
Per Company:	No

Company	Amount	Date Processed	Transaction #
Security Mutual Life Insurance Company of New York	$900.00	12/28/2012	66086580

SERFF Tracking #:	*SMNY-128769403*	***State Tracking #:***		***Company Tracking #:***	*0012950AR 11/2012*

State:	*Arkansas*	***Filing Company:***	*Security Mutual Life Insurance Company of New York*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Applications*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/04/2013	01/04/2013

SERFF Tracking #:	*SMNY-128769403*	***State Tracking #:***		***Company Tracking #:***	*0012950AR 11/2012*

State:	*Arkansas*	***Filing Company:***	*Security Mutual Life Insurance Company of New York*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Applications*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/04/2013
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Application for Individual Life Insurance Part 1		Yes
Form	Application for Individual Life Insurance Part 2 Non-Medical		Yes
Form	Application for Individual Life Insurance Part 2 Medical		Yes
Form	Individual Insurance Application Confidential Financial Statement		Yes
Form	Conditional Receipt		Yes
Form	Important Notices		Yes
Form	Application Supplement for Financed Insurance		Yes
Form	Aviation Questionnaire		Yes
Form	Avocation Questionnaire		Yes
Form	Drug Usage Questionnaire		Yes
Form	Alcohol Usage Questionnaire		Yes
Form	Military Questionnaire		Yes

SERFF Tracking #:	*SMNY-128769403*	***State Tracking #:***		***Company Tracking #:***	*0012950AR 11/2012*

State:	*Arkansas*	***Filing Company:***	*Security Mutual Life Insurance Company of New York*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Applications*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Foreign Travel/Residence Questionnaire		Yes
Form	Application for Reinstatement of Individual Life Insurance Part 1		Yes
Form	Amendment to Application		Yes
Form	Statement of Good Health and Insurability		Yes
Form	Application for Term Conversion		Yes
Form	Application for Life Insurance Within a Pension or Profit Sharing Plan		Yes

SERFF Tracking #:	*SMNY-128769403*	***State Tracking #:***		***Company Tracking #:***	*0012950AR 11/2012*

State:	*Arkansas*	***Filing Company:***	*Security Mutual Life Insurance Company of New York*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Applications*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: 0012950AR 11/2012

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Individual Life Insurance Part 1	0012950AR 11/2012	AEF	Initial		0.000	0012950AR_112012.pdf
2		Application for Individual Life Insurance Part 2 Non-Medical	0013048AR 11/2012	AEF	Initial		0.000	0013048AR_112012.pdf
3		Application for Individual Life Insurance Part 2 Medical	0013050AR 11/2012	AEF	Initial		0.000	0013050AR_112012.pdf
4		Individual Insurance Application Confidential Financial Statement	0013044AR 11/2012	AEF	Initial		0.000	0013044AR_112012.pdf
5		Conditional Receipt	0013016AR 11/2012	OTH	Initial		0.000	0013016AR_112012.pdf
6		Important Notices	0013046XX 08/2012	OTH	Initial		0.000	0013046XX_082012.pdf
7		Application Supplement for Financed Insurance	0013029AR 11/2012	AEF	Initial		0.000	0013029AR_112012.pdf
8		Aviation Questionnaire	0013004AR 11/2012	AEF	Initial		0.000	0013004AR_112012.pdf
9		Avocation Questionnaire	0013010AR 11/2012	AEF	Initial		0.000	0013010AR_112012.pdf

SERFF Tracking #: SMNY-128769403 **State Tracking #:** **Company Tracking #:** 0012950AR 11/2012

State: Arkansas **Filing Company:** Security Mutual Life Insurance Company of New York
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Applications
Project Name/Number: /

Lead Form Number: 0012950AR 11/2012

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
10		Drug Usage Questionnaire	0013006AR 11/2012	AEF	Initial		0.000	0013006AR_112012.pdf
11		Alcohol Usage Questionnaire	0013008AR 11/2012	AEF	Initial		0.000	0013008AR_11fp2012.pdf
12		Military Questionnaire	0013014AR 11/2012	AEF	Initial		0.000	0013014AR_112012.pdf
13		Foreign Travel/Residence Questionnaire	0013012AR 11/2012	AEF	Initial		0.000	0013012AR_112012.pdf
14		Application for Reinstatement of Individual Life Insurance Part 1	0012958AR 11/2012	AEF	Initial		0.000	0012958AR_11fp2012.pdf
15		Amendment to Application	0013061AR 11/2012	AEF	Initial		0.000	0013061AR_112012.pdf
16		Statement of Good Health and Insurability	0013040AR 11/2012	AEF	Initial		0.000	0013040AR_112012.pdf
17		Application for Term Conversion	0011832AR 12/2012	AEF	Initial			0011832AR_122012.pdf
18		Application for Life Insurance Within a Pension or Profit Sharing Plan	0013071AR 12/2012	AEF	Initial			0013071AR_122012.pdf

Form Type Legend:

SERFF Tracking #:	*SMNY-128769403*	***State Tracking #:***	***Company Tracking #:*** *0012950AR 11/2012*

State:	*Arkansas*	***Filing Company:***	*Security Mutual Life Insurance Company of New York*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Applications*		
Project Name/Number:	*/*		

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607.723.3551 • www.smlny.com

Application for Individual Life Insurance — Part 1

(Please print or type all information in black ink.)

❑ New Business
❑ Policy Change (Policy # _____)

SECTION 1. Proposed Insured

A) Full Legal Name (First, Middle Initial, Last) (Alias/Maiden Name): **B)** Social Security Number: **C)** Sex: ❑ Male ❑ Female

D) Date of Birth: Birth City: State: Country:

E) Marital Status: ❑ Single ❑ Legally Married ❑ Widowed ❑ Separated or Divorced ❑ Domestic Partnership

F) U.S. Citizen ❑ Yes ❑ No If "No", complete H.

G) U.S. Driver's License, if not licensed, please indicate other form of ID: ❑ Passport ❑ Gov't Issued Photo ID
ID Number: State of Issue: Issue Date *(if any)*: Expiration Date *(if any)*:

H) Non U.S. Citizen ID:
Country of Citizenship: Country of Permanent Residence: Years in the U.S.:
Green Card/VISA Type: Green Card/VISA ID Number: Expiration Date:

I) Permanent Home Address (Number, Street, Apt. #, City, State, Zip Code): **J)** How long at address?

K) Previous address (only if within last 2 years):

L) Primary Telephone Number: Cell Phone Number: E-mail Address:

M) Employer Name: **N)** How long with Employer?

O) Address:

P) Occupation and duties:

Q) Any change contemplated to employment? ❑ Yes ❑ No (If "Yes", give details in Section 13 Remarks.)

R) Is the Proposed Insured actively performing all the duties of his/her regular occupation (including homemaker, student or retired)?
❑ Yes ❑ No If "No", is the Proposed Insured currently disabled? ❑ Yes ❑ No If "Yes", give details in Section 13 Remarks.

S) Answer if Proposed Insured is at least 15 days old and under 14 yrs. 6 mos. **(Explain any "No" answer in "Remarks" below)**

1. Please advise purpose of insurance_____
2. Is Applicant a parent or legal guardian (attach proof of guardianship) of Proposed Insured? ..... ❑ Yes ❑ No
3. Is Applicant employed and providing Proposed Insured's main support? ..... ❑ Yes ❑ No
4. Life insurance in force with all companies on parent or legal guardian 1 $_____ .
5. Life insurance in force with all companies on parent or legal guardian 2 $_____ .
6. Life insurance in force on the Applicant if other than parent(s) $ _____ .
7. Is each other child in the family insured or to be insured for an amount at least equal to that on the Proposed Insured? ❑ Yes ❑ No

Remarks:

SECTION 2. Owner: *Complete this section only if the Owner is not the Proposed Insured.*

If Owner is a Business, Trust, Pension Plan or other Entity, complete A.
If Owner is an Individual other than the Proposed Insured, complete B.
If naming a Joint Owner or Contingent Owner, give details in Section 13 Remarks.
❑ Check if Ownership should revert to the Insured upon Owner(s)' and Contingent Owner's death.

A) 1. ❑ Business Entity (if Entity is not publicly traded, complete the Business Entity Ownership Certification Form)
❑ Trust (complete the Trust Certification Form)
❑ Qualified Pension Plan (complete Pension Plan Questionnaire and Authorization to Release Information Form)
❑ Other (Specify):

2. Complete Name of Business/Trust/Other Entity: 3. Taxpayer ID Number: 4. State of Organization/Incorporation:

5. Address (Number, Street, Apt #, City, State, Zip Code):

6. Trustee Name(s): 7. Trust Date:

B) 1. ❑ Full Legal Name (First, Middle Initial, Last):

2. Date of Birth: 3. Social Security Number:

4. U.S. Citizen ❑ Yes ❑ No If "No", complete 5.

5. Non U.S. Citizen ID:

Country of Citizenship: Country of Permanent Residence: Years in the U.S.:

Green Card/VISA Type: Green Card/VISA ID Number: Expiration Date:

6. Permanent Home Address (Number, Street, Apt. #, City, State, Zip Code): How long at address?

7. Primary Telephone Number: 8. Cell Phone Number: 9. E-mail Address:

10. Relationship to Proposed Insured:

If named, the Contingent Owner shall become the Owner (a "Successor" or "Contingent" Owner) if the Owner dies before the Insured. If the Successor or the Contingent Owner does not survive the Owner, then, upon the Owner's death, the Owner's estate shall become the Owner, unless otherwise noted.

SECTION 3. Applicant, if other than Owner

A) Full Legal Name (First, Middle Initial, Last): **B)** Date of Birth: **C)** Social Security Number

D) Address (Number, Street, Apt. #, City, State, Zip Code): **E)** Relationship to Proposed Insured:

SECTION 4. Other Information (must be completed)

A) Does the Owner(s), Proposed Insured or Applicant intend that any party, other than the Owner(s) designated in Section 2, will at any time, obtain any right, title or beneficial interest in any policy issued on the life of the Proposed Insured pursuant to this application? ❑ Yes ❑ No (If "Yes", provide details in Section 13 Remarks.)

B) Will all or part of the premiums be financed with funds borrowed, advanced or paid from another person or entity (whether or not interest is charged)? ❑ Yes ❑ No (If "Yes", provide details in Section 13 Remarks.)

C) Is the life insurance being applied for for the purpose of transfer or assignment to a viatical or life settlement company? ❑ Yes ❑ No

D) Are there any plans to sell the policy to another company or individual after it is issued, or will it replace a policy that has already been sold to another company? ❑ Yes ❑ No (If "Yes", provide details in Section 13 Remarks.)

SECTION 5. Beneficiary(ies) (If additional Beneficiaries are to be named, complete Section 10)

A) ❑ Check box if the Owner is to be the Primary Beneficiary; otherwise complete **B** to name an individual other than the Owner as Primary Beneficiary and **C** to name an individual as Contingent Beneficiary(ies) or **D** to name a Trust as Primary or Contingent Beneficiary or **E** to name a Business as Primary or Contingent Beneficiary. **NOTE: Signature of Spouse of Owner is required if this application is signed in a state that has Community Property Laws.** ***[AZ, CA, ID, LA, NV, NM, TX, WA, WI.]***

B) Individual(s) as Primary Beneficiary(ies):

Name_____ Sex_____ Relationship to Insured _____ % _____

Social Security No._____ Birthdate _____ Primary Telephone Number _____

Cell Phone Number_____ E-mail Address _____

Address _____

Name_____ Sex_____ Relationship to Insured _____ % _____

Social Security No._____ Birthdate _____ Primary Telephone Number _____

Cell Phone Number_____ E-mail Address _____

Address _____

C) Individual(s) as Contingent Beneficiary(ies)

Name_____ Sex_____ Relationship to Insured _____ % _____

Social Security No._____ Birthdate_____ Primary Telephone Number _____

Cell Phone Number_____ E-mail Address _____

Address _____

Name_____ Sex_____ Relationship to Insured _____ % _____

Social Security No._____ Birthdate _____ Primary Telephone Number _____

Cell Phone Number_____ E-mail Address _____

Address _____

D) Trust as Beneficiary (Only complete this section if you are naming a trust as beneficiary and the trust document will govern the disposition of the death benefit proceeds. A valid trust document must be in existence as of the date of this application.)

Trust is ❑ Primary ❑ Contingent Beneficiary

Trust Name: Trust Date: Tax Identification Number:

Trustee Name(s):

Address (Street, City, State, Zip): Percentage:

Trustee's Telephone Number: Cell Phone Number: E-mail Address:

E) Business as Beneficiary

Business is ❑ Primary ❑ Contingent Beneficiary

Full Business Name: Tax Identification Number:

Company Contact (Officer Name and Title):

Address (Street, City, State, Zip) Percentage:

Primary Telephone Number: Cell Phone Number: E-mail Address:

SECTION 6. Plan of Insurance (Complete the appropriate section)

A) WHOLE LIFE

1) Plan Name _____

2) Base policy face amount applied for $ _____ 3) Basic annual premium per thousand $ _____

4) Dividend Option (If the Custom Term Rider is applied for, dividends will be applied to purchase One-Year-Term Additions with any excess applied to purchase Paid-Up Additions)

❑ Paid in Cash ❑ Purchase Paid-Up Additions ❑ Accumulate at Interest ❑ Reduce Premiums
❑ Purchase One-Year Term Additions ❑ Purchase Paid-Up Whole Life Insurance

5) Nonforfeiture Option ❑ Extended Term Insurance ❑ Reduced Paid-Up Insurance

6) Automatic Premium Loan, if available? ❑ Yes ❑ No

7) Dividend Accumulations to be applied to pay unpaid premiums, if available? ❑ Yes ❑ No

SUPPLEMENTARY BENEFITS (some benefits may not be available in all states)

8) a. ❑ Custom Term Rider Death Benefit $ _____
b. ❑ Level Term Rider Death Benefit $ _____

9) ❑ Paid-Up Additions Rider
a. One time payment of $_____(must be paid with the initial premium)
or
b. Initial modal premium of $_____, c. with subsequent modal premiums of $_____.
d. Paid-Up Additions Rider Premium paid for a total of _____ years.

10) ❑ Waiver of Premium 11) ❑ Accidental Death Benefit Rider $_____ 12) ❑ Insurance Exchange Rider

13) ❑ Enhanced Guaranteed Insurability Option Type:_____ Amount $_____

14) ❑ Terminal Illness Options Accelerated Benefit Rider (See disclosure at the end of Section 6)*

15) ❑ Chronic Illness Accelerated Death Benefit Rider (Includes Terminal Illness Options Accelerated Benefit Rider. See disclosure at the end of Section 6.)*

16) ❑ Flexible Premium Annuity Rider (Complete a-e)

a. Stipulated Premium $_____ b. Amount paid with application $_____

c. Do you elect to have the premiums, or any portion thereof, on this policy paid from this Rider? ❑ Yes ❑ No

d. Maturity Date

❑ The proposed annuitant's 65th birthday if it falls on the first day of the month. If it does not, the first day of the month following the proposed annuitant's 65th birthday.

❑ First date of Month_____ Year _____

(Proposed annuitant will be the Proposed Insured)

e. SPECIAL ISSUE INSTRUCTIONS _____

17) ❑ Other Benefits, indicate type (and amount if applicable) _____

B) TERM LIFE

1) Plan Name _____

2) Face Amount applied for $_____

3) Level Premium Period

❑ 1 Year ❑ 10 Year ❑ 15 Year ❑ 20 Year ❑ 30 Year ❑ Other _____

4) ❑ Monthly Benefit Life**: a. Level Premium Period _____Years (15-40 Years; 35-Year Maximum for Smokers)

b. Monthly Benefit applied for $_____ c. ❑ Fixed Monthly Benefit **OR** ❑ Monthly Benefit with 3% annual increase

**The death benefit is paid to the beneficiary in the form of a monthly benefit. If the insured dies prior to the Final Expiry Date stated in the policy, the first monthly benefit payment will be due as of the insured's death. No lump sum death benefit is payable under this policy. The policyowner should seek legal advice before naming an estate as beneficiary, and should review the beneficiary designation periodically to ensure that it is up to date. If monthly benefits are payable to an estate, it may be necessary to keep the estate open for the duration of the benefit period, depending on applicable law.

Tax Disclosure: Each monthly benefit payment received by the beneficiary will be treated for tax purposes as part tax-exempt death benefit and part taxable interest income. The method of allocating the tax exempt and taxable portions of the payments is prescribed by IRS regulations. This explanation is based on the Company's understanding of the current income tax laws. Tax laws are subject to change. A taxpayer should seek advice from an independent tax advisor regarding the taxpayer's particular circumstances.

5) Dividend Option ❑ Paid in Cash ❑ Reduce Premiums

SUPPLEMENTARY BENEFITS (some benefits may not be available in all states)

6) ❑ Waiver of Premium

7) ❑ Accidental Death Benefit Rider $_____

8) ❑ Terminal Illness Options Accelerated Benefit Rider* (See disclosure at the end of Section 6)*

9) ❑ Enhanced Conversion Rider

10) ❑ Other Riders/Benefits, indicate type (and amount if applicable) _____

C) UNIVERSAL LIFE

1) Plan Name _____

2) Type of Policy ❑ Single Life ❑ Survivorship (complete a separate application for each insured)

3) Specified Amount applied for (base only) $_____

4) Initial Modal Premium (including lump sum deposit plus exchange proceeds) $_____

5) Planned Periodic Modal Premium $_____

6) Death Benefit Option

❑ Option A (Specified Amount) ❑ Option B (Specified Amount plus Accumulation Value)

❑ Option C (Specified Amount plus Cumulative Premiums) ❑ Other _____

7) Life Insurance Qualification Test, if applicable:

❑ Cash Value Accumulation Test **OR** ❑ Guideline Premium Test

8) No Lapse Guarantee, if applicable:

a. ❑ NLG Period _____ years **OR** b. ❑ NLG Monthly Premium $_____

SINGLE LIFE SUPPLEMENTARY BENEFITS

9) ❑ Waiver of Monthly Deduction

10) ❑ Overloan Protection Rider***

11) ❑ Terminal Illness Options Accelerated Benefit Rider (See disclosure at the end of Section 6)*

12) ❑ Chronic Illness Accelerated Death Benefit Rider (Includes Terminal Illness Options Accelerated Benefit Rider. See disclosure at the end of Section 6.)*

13) ❑ Guaranteed Purchase Option

14) ❑ Accidental Death Benefit Rider $_____

15) ❑ Primary Insured Term Rider $_____

16) ❑ Other Benefits/Riders, indicate type (and amount if applicable.) _____

***As set forth in the Policy Loans provision of the Policy, the Policy will terminate if Policy loans and loan interest equal or exceed the Cash Value of the Policy, plus the Cash Value of any paid-up additions purchased with dividends. Under tax laws currently in effect, upon the termination of a life insurance policy, all loans, withdrawals and net cash surrender value received become taxable in the year of termination to the extent that these exceed the Owner's investment in the Policy. The Owner's investment in the Policy is the aggregate amount of premiums paid for the Policy, minus the aggregate amount received under the Policy to the extent that such amount was excludable from taxable income. It is the intent of the Rider Benefit to prevent the Policy from terminating due to loan indebtedness, such that no Policy loans or withdrawals will become taxable, however, the Internal Revenue Service (IRS) has not ruled with respect to the tax aspects of the Rider Benefit. It is possible that the IRS could rule that the operation of this Rider is equivalent for tax purposes to the termination of the Policy. The Owner should consult the Owner's tax advisor prior to the Rider Benefit becoming effective.

SURVIVORSHIP SUPPLEMENTARY BENEFITS

17) ❑ Terminal Illness Options Accelerated Benefit Rider*
18) ❑ Split Option Rider – Divorce
19) ❑ Split Option Rider – Estate Tax Law Change
20) ❑ Split Option Rider – Business Dissolution
21) ❑ Term Life Insurance Rider $ _____
22) ❑ Other (please specify)_____

The Owner understands that if accelerated death benefits are paid under any accelerated benefit rider, receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. The portion of the death benefit that is accelerated will be discounted and an administrative expense charge may be deducted from the accelerated death benefit.

SECTION 7. Policy Date. If no "Specified Date" is shown below, Policy Date will be the current date.

a) ❑ Date to save age. (Backdating to save age requires modal premiums to be paid from Policy Date.)
b) ❑ Specified Date: Month_____ Day _____ Year _____

SECTION 8. Payment Information

A) Has money been paid with this application? ❑ Yes ❑ No **(If "Yes", complete Conditional Receipt.)**

B) The undersigned Soliciting Agent acknowledges 1) that he/she received $_____ from the Applicant and that a copy of the Conditional Receipt has been given to the Applicant.

C) Premium Frequency: ❑ Annually ❑ Semi-Annually ❑ Quarterly ❑ EFT (Monthly Electronic Funds Transfer) ❑ List Bill
For Term and Whole Life Insurance there is an additional charge for the convenience of paying more frequently than annually. For Universal Life Insurance, the date(s) of payment will affect policy values.

D) Who will pay the premiums for this policy (payor)? ❑ Owner ❑ Proposed Insured ❑ Spouse ❑ Other - if other, provide information below:

Name: Date of Birth: Social Security or Taxpayer Identification Number:

Address (Number, Street, Apt. #, PO Box, City, State, Zip): Relationship to Proposed Insured/Owner(s): Reason:

E) Mailing Address for all communications including Premium Billing:
❑ Proposed Insured ❑ Owner ❑ Joint Owner ❑ Applicant ❑ Payor ❑ Other

SECTION 9. Secondary Addressee (If none, proceed to Section 10)

Do you wish to designate another person to receive copies of any premium or lapse notices sent to you?
If "Yes", please provide the following:
Name: Date of Birth:

Address (Number, Street, Apt. #, PO Box, City, State, Zip): E-mail Address:

SECTION 10. Special Issue Instructions

SECTION 11. Existing Insurance

A) Does ***Owner or Applicant*** have any life insurance or annuity contracts in force with any insurer? ❑ Yes ❑ No

B) List all life insurance and annuities in force on the **PROPOSED INSURED**. Include any policy that has been sold, assigned or settled to a settlement or viatical company or any other person or entity. If none, proceed to Section 12.

Indicate Type of coverage: Group (G); Business (B); Personal (P); or Annuity (A)

Insurance Company	Face Amount, Including Riders	Policy Number	Year Issued	Type	To Be Replaced		1035 Exchange		Settled or Sold	
					Yes	No	Yes	No	Yes	Year
1.					❑	❑	❑	❑	❑	
2.					❑	❑	❑	❑	❑	
3.					❑	❑	❑	❑	❑	
4.					❑	❑	❑	❑	❑	

C) Is the life insurance or annuity now being applied for on the Proposed Insured intended to replace or change any life insurance or annuities in any Company? ❑ Yes ❑ No

SECTION 12. General Risk Questions TO BE ANSWERED BY PROPOSED INSURED (referred to in this Section 12 as "you")

A) Have you ever used any tobacco/nicotine products, such as cigarettes, cigars, cigarillos, a pipe, chewing tobacco or nicotine delivery device such as nicotine patches or nicotine gum? (If "Yes", provide details below)..... ❑ Yes ❑ No

Product	Frequency Using	Currently Use	Past Use	Date Last Used mm/yyyy
1. Cigarettes	_____packs/day	❑	❑	
2. Cigars	_____ x/day _____ x/month	❑	❑	
3. Pipe	_____ x/day _____ x/month	❑	❑	
4. Other: _____ x/day specify type of product		❑	❑	

B) 1. Are there any other applications or negotiations for life insurance or reinstatement of life insurance pending or contemplated with respect to which you are to be the insured life? ..... ❑ Yes ❑ No
(If "Yes", provide name of company, purpose of coverage and amount of coverage, also indicate the amount intended to be placed or put in effect in Section 12-K. Include ultimate death benefit amounts of any policy rider.)

2. Have you ever withdrawn an application or informal inquiry for insurance from consideration? ..... ❑ Yes ❑ No
(If "Yes", provide details in Section 12-K.)

C) Have you flown as a trainee, pilot or crew member within the last 3 years or do you contemplate any such flight in the future? ..... ❑ Yes ❑ No
(If "Yes", complete Aviation Questionnaire.)

D) Have you ever had a driver's license suspended, restricted, revoked, expired or been convicted of or pled guilty to driving under the influence of alcohol or drugs; or in the last 5 years been convicted of a moving violation? ..... ❑ Yes ❑ No
(If "Yes", provide full details, including dates, types of violation and reason for license suspension or revocation in Section 12-K)

E) Have you within the last 3 years engaged in, or do you plan within the next 2 years, to engage in motor racing on land or water, underwater diving or use of a submarine, sky diving, ballooning, hang gliding, parachuting, paraskiing or parakiting, biplaning, mountain, rock or ice climbing, competitive skiing, snowboarding, luging, boxing, wrestling, mixed martial arts, big game hunting, or rodeo or equine sports? ..... ❑ Yes ❑ No
(If "Yes", complete Avocation Questionnaire)

F) Do you intend to travel or reside outside the United States or Canada within the next 12 months? ..... ❑ Yes ❑ No
(If "Yes", provide details in Section 12-K.)

G) Have you ever had an application for life or health insurance declined, postponed, rated or modified in any way? .. ❑ Yes ❑ No
(If "Yes", provide details in Section 12-K.)

H) Have you ever been convicted of a felony, or pled guilty or no contest to a criminal offense? ..... ❑ Yes ❑ No
(If "Yes", provide details in Section 12-K.)

I) Are you a member of or have you entered into a written agreement to join one of the Armed Forces or an active or reserve military unit? ❑ Yes ❑ No
(If "Yes", complete Military Questionnaire)

J) Are you financially dependent upon someone else? ..... ❑ Yes ❑ No
(If "Yes", provide name, relationship and amount of life insurance in force on such person in Section 12-K.)

K) Use this section to provide details for "Yes" answers to questions 12-A to 12-J. Identify applicable question numbers.

SECTION 13. REMARKS

SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607.723.3551 • www.smlny.com

(Must be Completed)

INDIVIDUAL INSURANCE APPLICATION CONFIDENTIAL FINANCIAL STATEMENT

To be signed by the Proposed Insured's accountant if Face Amount/Specified Amount is $5 million or more (issue ages 69 and younger) and $2 million or more (ages 70 and older). In lieu of accountant's signature, the Company may, in its sole discretion, accept appropriate personal or business financial statements.

1. Name of Proposed Insured _____ Amount of Insurance Requested $ _____

2. **Business Insurance:** Answer questions 2, 4, 5, 6, 7, 8 & 9
   Name of Business: _____ Website Address: _____
   Purpose of Insurance
   ❑ Key Person ❑ Buy/Sell ❑ Stock Redemption ❑ Deferred Compensation ❑ Tax Planning
   ❑ Required by creditor (debt protection) ❑ Split Dollar ❑ Other _____

3. **Personal Insurance:** Answer questions 3, 4, 5, 7, 8 & 9
   Purpose of Insurance
   ❑ Final Expenses ❑ Family Protection ❑ Charitable Giving ❑ Estate Liquidity ❑ Loan Protection ❑ Retirement Planning
   ❑ Other _____

4. Explain in detail the need for the insurance amount requested
   _____

5. In the last five years, has either the Proposed Insured(s) or the business named in item 2, had any major financial problems (bankruptcy, etc.)? ❑ Yes ❑ No If "Yes", provide details.

6. Is Proposed Insured an owner in the business named in item 2? ❑ Yes ❑ No % of Ownership? _____
   Are other partners, corporate officers or keypersons insured or being insured with similar amounts? ❑ Yes ❑ No
   If "No", why not? _____
   For other owners or partners, list the following (attach additional sheets if necessary):

Name	Date of Birth	Title	% Ownership	Amount of Business Insurance	
				In Force	Applied For

   Net worth of business: Book Value $ _____ Fair Market Value $ _____
   How was the Fair Market Value of the business determined? _____
   Gross Annual Sales $ _____ Net Annual Income of Business (before taxes) $ _____
   Is insurance required by creditor? ❑ Yes ❑ No If "Yes", provide the following:
   Name of Creditor _____
   Amount of Loan $ _____ Term of Loan _____

7. Proposed Insured's Personal Finances:

	Last Year	Previous Year
Salary	$ _____	$ _____
Bonus	_____	_____
Other	_____	_____
Unearned Income (interest, rentals, etc.)	_____	_____
Total	$ _____	$ _____

8. Indicate source of funds used to purchase the insurance: ❑ Income ❑ Investments/Savings ❑ Loans ❑ Gifts/Inheritances
   ❑ Settled Life Insurance Contract(s) — Give Details In Section 10 Remarks ❑ Other (Specify) _____

9. Current personal financial status:

Total Assets at current market value	$ _____
Total Liabilities	$ _____
NET WORTH	$ _____

10. Remarks: _____

I represent that the above statements are full, complete and true to the best of my knowledge and belief. This Confidential Financial Statement is a part of the application for insurance.

Name of Accountant or other financial professional (Print) _____ Phone No. _____

Name of Firm _____ License No. _____

Accountant's Business Address (Street, PO Box, City, State and Zip) _____

Signature of Accountant or other financial professional _____

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Application for Individual Life Insurance—Part 2 – Non- Medical

QUESTIONS TO BE ANSWERED BY PROPOSED INSURED NAMED IN APPLICATION PART 1 (referred to in this Part 2 as "YOU").

(Please print or type all information in black ink.)

Name of Proposed Insured _____ Date of Birth _____

1. FAMILY HISTORY
Have any of your immediate family members (parents, brothers and sisters) died or been diagnosed as having cancer, coronary artery disease, stroke, kidney disease or diabetes? ❑ Yes ❑ No If "No", proceed to question 2.

		Age if Living	Age at Death	Give details of cause of death or diagnosis and age at diagnosis.
A.	Mother			
B.	Father			
C.	Sister(s)			
D.	Brother(s)			

2. Your Height _____ Weight _____
Describe any weight change in past 12 months ❑ Gained ❑ Lost _____ lbs. Reason _____

3. A. Name of your personal physician(s) (First, Middle Initial, Last) _____
Address (Number, Street, Apt. #, City, State, Zip) _____
Specialty, if any _____
B. Date of last visit _____
C. Diagnosis or outcome of last visit _____
D. What treatment was given or medication(s) prescribed? _____
_____ If none, check ❑
E. List all medications used in the past year _____
_____ If none, check ❑
F. Physician who can provide us with the most complete and up-to-date medical records (if different from above).
Name of Physician (First, Middle Initial, Last) _____
Address (Number, Street, Apt. #, City, State, Zip) _____
G. Do you have any appointment with a medical professional or have any medical care scheduled? ❑ Yes ❑ No
If "Yes", provide details _____

If you answer "Yes" to any of the following questions, circle applicable medical condition and provide details in question 10.

4. Have you ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for:
A. Coronary artery disease, chest pain, angina, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, fainting spells or other disorder of the heart? ❑ Yes ❑ No
B. Diabetes or any disorder of the thyroid, pituitary, adrenals, pancreas or other endocrine disorder? ❑ Yes ❑ No
C. Skin disease, growth, rash, tumor or cyst? ❑ Yes ❑ No
D. Kidney stone, or any disease of the kidneys, bladder, prostate, testicles, breasts, uterus, ovaries, or any other part of the urinary tract or reproductive system? ❑ Yes ❑ No
E. Convulsions, seizures, epilepsy, stroke, TIA (transient ischemic attack (mini-stroke)), Alzheimer's Disease, dementia, Parkinson's Disease, Multiple Sclerosis, ALS (amyotrophic lateral sclerosis), neuropathy or recurrent dizziness or headaches? ❑ Yes ❑ No
F. Shortness of breath, sleep apnea, asthma, cystic fibrosis, emphysema, chronic lung disease, tuberculosis, asbestosis, coughing up or spitting up of blood, pneumonia, bronchitis, pleurisy, hoarseness or cough lasting more than 6 weeks, or any other disorder of the lungs or respiratory system? ❑ Yes ❑ No

G. Jaundice, intestinal bleeding, persistent diarrhea, ulcer, esophagitis, Barrett's esophagus, gastritis, duodenitis, pancreatitis, colitis, diverticulitis, hepatitis, Crohn's Disease, Ulcerative Colitis or other disorder of the esophagus, stomach, liver, gallbladder, pancreas, intestines or rectum? ❑ Yes ❑ No

H. Any disorder or disease of eyes, ears, nose or throat? ❑ Yes ❑ No

I. Phlebitis, blood clot, thrombosis, embolus, aneurysm, arterial narrowing, vasculitis or gangrene? ❑ Yes ❑ No

J. Amputation, deformity, osteoarthritis, lupus, rheumatoid arthritis, scleroderma, or other injury or disorder of the back, neck, muscles bones, joints or spine? ❑ Yes ❑ No

K. Mental or emotional disorder, depression, anxiety disorder, ADD (attention deficit disorder), ADHD (attention deficit / hyperactivity disorder), schizophrenia, bipolar disorder or other psychosis, psychiatric or neurological disorder? ❑ Yes ❑ No

L. Cancer, tumor, mass or growth of any kind arising in or spreading to any organ or tissue of the body including the blood, bone marrow or lymph glands? ❑ Yes ❑ No

M. Any infection, inflammation, anemia, polycythemia, immune deficiency (other than HIV) or other inherited or acquired condition not mentioned above? ❑ Yes ❑ No

N. Any surgery or biopsy? Any catheterization of the heart or arteries? ❑ Yes ❑ No

O. Within the past 12 months have you been under observation by a member of the medical profession or taking medication or treatment for any illness, condition or injury not mentioned above? ❑ Yes ❑ No

5. Have you been diagnosed with or treated for AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) by a licensed member of the medical profession? ❑ Yes ❑ No

6. Other than as disclosed above, have you within the past 5 years:

A. Been a patient in a hospital, clinic, or other medical or treatment facility? ❑ Yes ❑ No

B. Been advised by a member of the medical profession to have any diagnostic test or procedure, hospitalization, treatment, or surgery, whether or not completed (other than HIV)? ❑ Yes ❑ No

7. Have you ever used any narcotic, sedative, hallucinogenic, marijuana, crack, cocaine, heroin, LSD, or any illegal, restricted or controlled substance, or any other drugs, except as prescribed by a physician? ❑ Yes ❑ No

If "Yes", provide name(s), form(s), quantity, frequency and duration of use, and date last used, for each drug and/or substance used. _____

_____

8. Have you ever:

A. Been advised to reduce or discontinue the use of alcohol? ❑ Yes ❑ No

B. Been counseled, sought help or treatment, or been advised to go for treatment or counseling for alcoholism or drug use? ❑ Yes ❑ No

C. Attended or joined any organization such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) for alcohol and/or drug-related problems? ❑ Yes ❑ No

9. Are you now pregnant? ❑ Yes ❑ No

If "Yes", how many months? _____

10. Please give details of all "Yes" answers – Question Number, when (each instance), nature of illness or injury, number of attacks, duration, severity, length of illness, after effects, treatment names, addresses and telephone number of medical professionals, clinics and hospitals involved (attach additional sheets of paper, if necessary.)

AUTHORIZATION TO OBTAIN INFORMATION

- By my signature below, I, the Proposed Insured and I, the Owner, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, MIB, Inc., consumer credit reporting agency, Department of Motor Vehicles, or present or former employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, and any other medical or non-medical information about me or my health, including motor vehicle and driving records, to give to Security Mutual Life Insurance Company of New York or its legal representative, or any reinsuring company or its legal representative, any and all such information. This authorization excludes psychotherapy notes.
- To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency engaged by Security Mutual Life Insurance Company of New York to collect and transmit such information.
- I authorize Security Mutual Life Insurance Company of New York, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. at any time within two years from the date of this Authorization.
- I understand the information obtained by use of this Authorization will be used by Security Mutual Life Insurance Company of New York to determine eligibility and the premium rate for insurance. Any information obtained will not be released by Security Mutual Life Insurance Company of New York to any person or organization except to reinsuring companies, MIB, Inc., other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.
- I understand that I may request to receive a copy of this Authorization.
- I agree that a photocopied, facsimile or e-mailed copy of this Authorization shall be as valid as the original.
- **I acknowledge having received and read the Notice Regarding Possible Investigative Consumer Report and the MIB, Inc. Disclosure Notice.**
- I authorize Security Mutual Life Insurance Company of New York to request an investigative consumer report.
- I agree that this Authorization shall remain valid for 24 months from its date unless I revoke it by written notice to Security Mutual Life Insurance Company of New York.

AGREEMENT/DISCLOSURE

I, the Proposed Insured and I, the Owner, and I, the Applicant, by my signature below, hereby acknowledge my understanding and agreement that:

(1) No person (including any agent, broker or medical examiner) other than the President, a Vice President or a Secretary of Security Mutual Life Insurance Company of New York (the "Company") has authority to receive any information on behalf of the Company not contained in this application, or to make, modify or enlarge any contract, or to waive any requirement.

(**2**) **EXCEPT AS PROVIDED IN ANY CONDITIONAL RECEIPT ISSUED, ANY POLICY ISSUED PURSUANT TO THIS APPLICATION SHALL TAKE EFFECT ON THE DATE IT IS DELIVERED TO THE OWNER AND THE FIRST PREMIUM IS PAID DURING THE LIFETIME OF EACH AND EVERY PERSON PROPOSED FOR INSURANCE UNDER SUCH POLICY AND THEN ONLY IF THE HEALTH AND OTHER CONDITIONS AFFECTING INSURABILITY REMAIN AS DESCRIBED IN THIS APPLICATION, AND ANY AND ALL STATEMENTS AND ANSWERS PROVIDED ANYWHERE IN THIS APPLICATION, TOGETHER WITH THOSE IN ANY PART 1 OR 2 AND IN ANY SUPPLEMENTAL APPLICATION OR CONFIDENTIAL FINANCIAL STATEMENT MADE IN CONNECTION HEREWITH (TOGETHER, THE "INSURANCE APPLICATION") CONTINUE TO BE FULL, COMPLETE AND TRUE, WITHOUT MATERIAL CHANGE, AS OF THE DATE THE FULL FIRST PREMIUM IS PAID; ALL LATER PREMIUMS WILL BE DUE ON THE DATES SPECIFIED IN THE POLICY.**

(3) Any and all statements and answers provided anywhere in the Insurance Application and any supplements or attachments thereto are full, complete and true to the best of my knowledge and belief, have been accurately recorded in the Insurance Application and the Company will rely on such statements and answers in the Company's consideration of this Insurance Application, and such statements and answers are made to the Company to induce the Company to issue the policy or policies applied for and will be attached to and made a part of any policy issued. I agree to notify the Company of any changes to the statements and answers given in any part of the Insurance Application before accepting delivery of any policy.

The undersigneds each represent that the Owner, the Applicant and the Proposed Insured each has read, or had read to each of them, the completed application and that they each realize that any false statement or misrepresentation which is material to the risk therein may result in loss of coverage under any policy issued hereunder.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Your signature on this application is certification that the Taxpayer Identification Number(s) provided on this application is correct and complete. The IRS does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.

Under penalties of perjury, I, the policy Owner, certify that:

(1) The number shown in this application is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and

(2) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

(3) I am a U.S. citizen or other U.S. person (including a U.S. resident alien).

You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on tax returns.

FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURES

_____ Signed at _____ Date of Signing _____

Signature of Proposed Insured or Parent or Legal Guardian if the Proposed Insured is a minor — (City, State) — (mm/dd/yyyy)

_____ _____

Signature of Owner (if other than Proposed Insured) — Title (if Business or Trust)

_____

Signature of Applicant (if other than Proposed Insured)

_____ _____ _____

Signature of Soliciting Agent — Print or Type Name of Soliciting Agent — Soliciting Agent License Number

_____ _____

Signature of Spouse (if Community Property State) — Print or Type Name of General Agent

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Application for Individual Life Insurance—Part 2 – Non- Medical

QUESTIONS TO BE ANSWERED BY PROPOSED INSURED NAMED IN APPLICATION PART 1 (referred to in this Part 2 as "YOU").

(Please print or type all information in black ink.)

Name of Proposed Insured _____ Date of Birth _____

1. FAMILY HISTORY
Have any of your immediate family members (parents, brothers and sisters) died or been diagnosed as having cancer, coronary artery disease, stroke, kidney disease or diabetes? ❑ Yes ❑ No If "No", proceed to question 2.

	Age if Living	Age at Death	Give details of cause of death or diagnosis and age at diagnosis.
A. Mother			
B. Father			
C. Sister(s)			
D. Brother(s)			

2. Your Height _____ Weight _____
Describe any weight change in past 12 months ❑ Gained ❑ Lost _____ lbs. Reason _____

3. A. Name of your personal physician(s) (First, Middle Initial, Last) _____
Address (Number, Street, Apt. #, City, State, Zip) _____
Specialty, if any _____
B. Date of last visit _____
C. Diagnosis or outcome of last visit _____
D. What treatment was given or medication(s) prescribed? _____
_____ If none, check ❑
E. List all medications used in the past year _____
_____ If none, check ❑
F. Physician who can provide us with the most complete and up-to-date medical records (if different from above).
Name of Physician (First, Middle Initial, Last) _____
Address (Number, Street, Apt. #, City, State, Zip) _____
G. Do you have any appointment with a medical professional or have any medical care scheduled? ❑ Yes ❑ No
If "Yes", provide details _____

If you answer "Yes" to any of the following questions, circle applicable medical condition and provide details in question 10.

4. Have you ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for:
A. Coronary artery disease, chest pain, angina, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, fainting spells or other disorder of the heart? ❑ Yes ❑ No
B. Diabetes or any disorder of the thyroid, pituitary, adrenals, pancreas or other endocrine disorder? ❑ Yes ❑ No
C. Skin disease, growth, rash, tumor or cyst? ❑ Yes ❑ No
D. Kidney stone, or any disease of the kidneys, bladder, prostate, testicles, breasts, uterus, ovaries, or any other part of the urinary tract or reproductive system? ❑ Yes ❑ No
E. Convulsions, seizures, epilepsy, stroke, TIA (transient ischemic attack (mini-stroke)), Alzheimer's Disease, dementia, Parkinson's Disease, Multiple Sclerosis, ALS (amyotrophic lateral sclerosis), neuropathy or recurrent dizziness or headaches? ❑ Yes ❑ No
F. Shortness of breath, sleep apnea, asthma, cystic fibrosis, emphysema, chronic lung disease, tuberculosis, asbestosis, coughing up or spitting up of blood, pneumonia, bronchitis, pleurisy, hoarseness or cough lasting more than 6 weeks, or any other disorder of the lungs or respiratory system? ❑ Yes ❑ No

G. Jaundice, intestinal bleeding, persistent diarrhea, ulcer, esophagitis, Barrett's esophagus, gastritis, duodenitis, pancreatitis, colitis, diverticulitis, hepatitis, Crohn's Disease, Ulcerative Colitis or other disorder of the esophagus, stomach, liver, gallbladder, pancreas, intestines or rectum? ❑ Yes ❑ No

H. Any disorder or disease of eyes, ears, nose or throat? ❑ Yes ❑ No

I. Phlebitis, blood clot, thrombosis, embolus, aneurysm, arterial narrowing, vasculitis or gangrene? ❑ Yes ❑ No

J. Amputation, deformity, osteoarthritis, lupus, rheumatoid arthritis, scleroderma, or other injury or disorder of the back, neck, muscles bones, joints or spine? ❑ Yes ❑ No

K. Mental or emotional disorder, depression, anxiety disorder, ADD (attention deficit disorder), ADHD (attention deficit / hyperactivity disorder), schizophrenia, bipolar disorder or other psychosis, psychiatric or neurological disorder? ❑ Yes ❑ No

L. Cancer, tumor, mass or growth of any kind arising in or spreading to any organ or tissue of the body including the blood, bone marrow or lymph glands? ❑ Yes ❑ No

M. Any infection, inflammation, anemia, polycythemia, immune deficiency (other than HIV) or other inherited or acquired condition not mentioned above? ❑ Yes ❑ No

N. Any surgery or biopsy? Any catheterization of the heart or arteries? ❑ Yes ❑ No

O. Within the past 12 months have you been under observation by a member of the medical profession or taking medication or treatment for any illness, condition or injury not mentioned above? ❑ Yes ❑ No

5. Have you been diagnosed with or treated for AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) by a licensed member of the medical profession? ❑ Yes ❑ No

6. Other than as disclosed above, have you within the past 5 years:

A. Been a patient in a hospital, clinic, or other medical or treatment facility? ❑ Yes ❑ No

B. Been advised by a member of the medical profession to have any diagnostic test or procedure, hospitalization, treatment, or surgery, whether or not completed (other than HIV)? ❑ Yes ❑ No

7. Have you ever used any narcotic, sedative, hallucinogenic, marijuana, crack, cocaine, heroin, LSD, or any illegal, restricted or controlled substance, or any other drugs, except as prescribed by a physician? ❑ Yes ❑ No
If "Yes", provide name(s), form(s), quantity, frequency and duration of use, and date last used, for each drug and/or substance used. _____

_____

8. Have you ever:

A. Been advised to reduce or discontinue the use of alcohol? ❑ Yes ❑ No

B. Been counseled, sought help or treatment, or been advised to go for treatment or counseling for alcoholism or drug use? ❑ Yes ❑ No

C. Attended or joined any organization such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) for alcohol and/or drug-related problems? ❑ Yes ❑ No

9. Are you now pregnant? ❑ Yes ❑ No
If "Yes", how many months? _____

10. Please give details of all "Yes" answers – Question Number, when (each instance), nature of illness or injury, number of attacks, duration, severity, length of illness, after effects, treatment names, addresses and telephone number of medical professionals, clinics and hospitals involved (attach additional sheets of paper, if necessary.)

AUTHORIZATION TO OBTAIN INFORMATION

- By my signature below, I, the Proposed Insured and I, the Owner, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, MIB, Inc., consumer credit reporting agency, Department of Motor Vehicles, or present or former employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, and any other medical or non-medical information about me or my health, including motor vehicle and driving records, to give to Security Mutual Life Insurance Company of New York or its legal representative, or any reinsuring company or its legal representative, any and all such information. This authorization excludes psychotherapy notes.
- To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency engaged by Security Mutual Life Insurance Company of New York to collect and transmit such information.
- I authorize Security Mutual Life Insurance Company of New York, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. at any time within two years from the date of this Authorization.
- I understand the information obtained by use of this Authorization will be used by Security Mutual Life Insurance Company of New York to determine eligibility and the premium rate for insurance. Any information obtained will not be released by Security Mutual Life Insurance Company of New York to any person or organization except to reinsuring companies, MIB, Inc., other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.
- I understand that I may request to receive a copy of this Authorization.
- I agree that a photocopied, facsimile or e-mailed copy of this Authorization shall be as valid as the original.
- **I acknowledge having received and read the Notice Regarding Possible Investigative Consumer Report and the MIB, Inc. Disclosure Notice.**
- I authorize Security Mutual Life Insurance Company of New York to request an investigative consumer report.
- I agree that this Authorization shall remain valid for 24 months from its date unless I revoke it by written notice to Security Mutual Life Insurance Company of New York.

I declare and represent that the statements and answers provided in this Application for Individual Life Insurance—Part 2 - Non-Medical have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application for insurance.

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____	_____	_____
Date	Signature of Agent	Signature of Proposed Insured

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Application for Individual Life Insurance—Part 2 – Medical

QUESTIONS TO BE ANSWERED BY PROPOSED INSURED NAMED IN APPLICATION PART 1 (referred to in this Part 2 as "YOU").

(Please print or type all information in black ink.)

Name of Proposed Insured _____ Date of Birth _____

1. FAMILY HISTORY
Have any of your immediate family members (parents, brothers and sisters) died or been diagnosed as having cancer, coronary artery disease, stroke, kidney disease or diabetes? ❑ Yes ❑ No If "No", proceed to question 2.

		Age if Living	Age at Death	Give details of cause of death or diagnosis and age at diagnosis.
A.	Mother			
B.	Father			
C.	Sister(s)			
D.	Brother(s)			

2. Your Height _____ Weight _____
Describe any weight change in past 12 months ❑ Gained ❑ Lost _____ lbs. Reason _____

3. A. Name of your personal physician(s) (First, Middle Initial, Last) _____
Address (Number, Street, Apt. #, City, State, Zip) _____
Specialty, if any _____
B. Date of last visit _____
C. Diagnosis or outcome of last visit _____
D. What treatment was given or medication(s) prescribed? _____
_____ If none, check ❑
E. List all medications used in the past year _____
_____ If none, check ❑
F. Physician who can provide us with the most complete and up-to-date medical records (if different from above).
Name of Physician (First, Middle Initial, Last) _____
Address (Number, Street, Apt. #, City, State, Zip) _____
G. Do you have any appointment with a medical professional or have any medical care scheduled? ❑ Yes ❑ No
If "Yes", provide details _____

If you answer "Yes" to any of the following questions, circle applicable medical condition and provide details in question 10.

4. Have you ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for:
A. Coronary artery disease, chest pain, angina, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, fainting spells or other disorder of the heart? ❑ Yes ❑ No
B. Diabetes or any disorder of the thyroid, pituitary, adrenals, pancreas or other endocrine disorder? ❑ Yes ❑ No
C. Skin disease, growth, rash, tumor or cyst? ❑ Yes ❑ No
D. Kidney stone, or any disease of the kidneys, bladder, prostate, testicles, breasts, uterus, ovaries, or any other part of the urinary tract or reproductive system? ❑ Yes ❑ No
E. Convulsions, seizures, epilepsy, stroke, TIA (transient ischemic attack (mini-stroke)), Alzheimer's Disease, dementia, Parkinson's Disease, Multiple Sclerosis, ALS (amyotrophic lateral sclerosis), neuropathy or recurrent dizziness or headaches? ❑ Yes ❑ No
F. Shortness of breath, sleep apnea, asthma, cystic fibrosis, emphysema, chronic lung disease, tuberculosis, asbestosis, coughing up or spitting up of blood, pneumonia, bronchitis, pleurisy, hoarseness or cough lasting more than 6 weeks, or any other disorder of the lungs or respiratory system? ❑ Yes ❑ No

G. Jaundice, intestinal bleeding, persistent diarrhea, ulcer, esophagitis, Barrett's esophagus, gastritis, duodenitis, pancreatitis, colitis, diverticulitis, hepatitis, Crohn's Disease, Ulcerative Colitis or other disorder of the esophagus, stomach, liver, gallbladder, pancreas, intestines or rectum? ❑ Yes ❑ No

H. Any disorder or disease of eyes, ears, nose or throat? ❑ Yes ❑ No

I. Phlebitis, blood clot, thrombosis, embolus, aneurysm, arterial narrowing, vasculitis or gangrene? ❑ Yes ❑ No

J. Amputation, deformity, osteoarthritis, lupus, rheumatoid arthritis, scleroderma, or other injury or disorder of the back, neck, muscles bones, joints or spine? ❑ Yes ❑ No

K. Mental or emotional disorder, depression, anxiety disorder, ADD (attention deficit disorder), ADHD (attention deficit / hyperactivity disorder), schizophrenia, bipolar disorder or other psychosis, psychiatric or neurological disorder? ❑ Yes ❑ No

L. Cancer, tumor, mass or growth of any kind arising in or spreading to any organ or tissue of the body including the blood, bone marrow or lymph glands? ❑ Yes ❑ No

M. Any infection, inflammation, anemia, polycythemia, immune deficiency (other than HIV) or other inherited or acquired condition not mentioned above? ❑ Yes ❑ No

N. Any surgery or biopsy? Any catheterization of the heart or arteries? ❑ Yes ❑ No

O. Within the past 12 months have you been under observation by a member of the medical profession or taking medication or treatment for any illness, condition or injury not mentioned above? ❑ Yes ❑ No

5. Have you been diagnosed with or treated for AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) by a licensed member of the medical profession? ❑ Yes ❑ No

6. Other than as disclosed above, have you within the past 5 years:

A. Been a patient in a hospital, clinic, or other medical or treatment facility? ❑ Yes ❑ No

B. Been advised by a member of the medical profession to have any diagnostic test or procedure, hospitalization, treatment, or surgery, whether or not completed (other than HIV)? ❑ Yes ❑ No

7. Have you ever used any narcotic, sedative, hallucinogenic, marijuana, crack, cocaine, heroin, LSD, or any illegal, restricted or controlled substance, or any other drugs, except as prescribed by a physician? ❑ Yes ❑ No

If "Yes", provide name(s), form(s), quantity, frequency and duration of use, and date last used, for each drug and/or substance used. _____

_____

8. Have you ever:

A. Been advised to reduce or discontinue the use of alcohol? ❑ Yes ❑ No

B. Been counseled, sought help or treatment, or been advised to go for treatment or counseling for alcoholism or drug use? ❑ Yes ❑ No

C. Attended or joined any organization such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) for alcohol and/or drug-related problems? ❑ Yes ❑ No

9. Are you now pregnant? ❑ Yes ❑ No

If "Yes", how many months? _____

10. Please give details of all "Yes" answers – Question Number, when (each instance), nature of illness or injury, number of attacks, duration, severity, length of illness, after effects, treatment names, addresses and telephone number of medical professionals, clinics and hospitals involved (attach additional sheets of paper, if necessary.)

AUTHORIZATION TO OBTAIN INFORMATION

- By my signature below, I, the Proposed Insured and I, the Owner, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, MIB, Inc., consumer credit reporting agency, Department of Motor Vehicles, or present or former employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment and any other medical or non-medical information about me or my health, including motor vehicle and driving records, to give to Security Mutual Life Insurance Company of New York or its legal representative, or any reinsuring company or its legal representative, any and all such information. This authorization excludes psychotherapy notes.
- To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency engaged by Security Mutual Life Insurance Company of New York to collect and transmit such information.
- I authorize Security Mutual Life Insurance Company of New York, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. at any time within two years from the date of this Authorization.
- I understand the information obtained by use of this Authorization will be used by Security Mutual Life Insurance Company of New York to determine eligibility and the premium rate for insurance. Any information obtained will not be released by Security Mutual Life Insurance Company of New York to any person or organization except to reinsuring companies, MIB, Inc., other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.
- I understand that I may request to receive a copy of this Authorization.
- I agree that a photocopied, facsimile or e-mailed copy of this Authorization shall be as valid as the original.
- **I acknowledge having received and read the Notice Regarding Possible Investigative Consumer Report and the MIB, Inc. Disclosure Notice.**
- I authorize Security Mutual Life Insurance Company of New York to request an investigative consumer report.
- I agree that this Authorization shall remain valid for 24 months from its date unless I revoke it by written notice to Security Mutual Life Insurance Company of New York.

I declare and represent that the statements and answers provided in this Application for Individual Life Insurance—Part 2 - Medical have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application for insurance.

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date	Signature of Medical Examiner	Signature of Proposed Insured

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INDIVIDUAL INSURANCE APPLICATION CONFIDENTIAL FINANCIAL STATEMENT

To be signed by the Insured or Proposed Insured's accountant if Face Amount/Specified Amount is $5 million or more (issue ages 69 and younger) and $2 million or more (ages 70 and older). In lieu of accountant's signature, the Company may, in its sole discretion, accept appropriate personal or business financial statements.

(Please print or type all information in black ink.)

1. Name of Insured or Proposed Insured _____ Amount of Insurance Requested $ _____

2. **Business Insurance:** Answer questions 2, 4, 5, 6, 7, 8 & 9
   Name of Business: _____ Website Address: _____
   Purpose of Insurance
   ❑ Key Person ❑ Buy/Sell ❑ Stock Redemption ❑ Deferred Compensation ❑ Tax Planning
   ❑ Required by creditor (debt protection) ❑ Split Dollar ❑ Other _____

3. **Personal Insurance:** Answer questions 3, 4, 5, 7, 8 & 9
   Purpose of Insurance
   ❑ Final Expenses ❑ Family Protection ❑ Charitable Giving ❑ Estate Liquidity
   ❑ Loan Protection ❑ Retirement Planning ❑ Other _____

4. Explain in detail the need for the insurance amount requested _____
   _____

5. In the last five years, has either the Insured or Proposed Insured(s) or the business named in item 2, had any major financial problems (bankruptcy, etc.)? ❑ Yes ❑ No If "Yes", provide details _____.

6. Is Insured or Proposed Insured an owner in the business named in item 2? ❑ Yes ❑ No % of Ownership? _____
   Are other partners, corporate officers or keypersons insured or being insured with similar amounts? ❑ Yes ❑ No
   If "No", why not? _____
   For other owners or partners, list the following (attach additional sheets if necessary):

Name	Date of Birth	Title	% Ownership	Amount of Business Insurance	
				In Force	Applied For

   Net worth of business: Book Value $ _____ Fair Market Value $ _____
   How was the Fair Market Value of the business determined? _____
   Gross Annual Sales $ _____ Net Annual Income of Business (before taxes) $ _____
   Is insurance required by creditor? ❑ Yes ❑ No If "Yes", provide the following:
   Name of Creditor _____
   Amount of Loan $ _____ Term of Loan

7. Proposed Insured's Personal Finances:

	Last Year	Previous Year
Salary	$ _____	$ _____
Bonus	_____	_____
Other	_____	_____
Unearned Income (interest, rentals, etc.)	_____	_____
Total	$ _____	$ _____

8. Indicate source of funds used to purchase the insurance: ❑ Income ❑ Investments/Savings ❑ Loans
❑ Gifts/Inheritances ❑ Settled Life Insurance Contract(s) — Give Details In Section 10 Remarks
❑ Other (Specify) _____

9. Current personal financial status: Total Assets at current market value $ _____
Total Liabilities $ _____
NET WORTH $ _____

10. Remarks:

AGREEMENTS AND SIGNATURES

I represent that the above statements are full, complete and true to the best of my knowledge and belief. I understand that this Questionnaire will be attached to and made a part of the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X _____ _____
Signature of Insured or Proposed Insured Date

X _____ _____
Signature of Agent Date

X _____ _____
Signature of Accountant or other financial professional Date

Name of Accountant (Print) _____ Phone No. _____

Name of Firm _____ License No. _____

Accountant's Business Address (Street, PO Box, City, State and Zip) _____

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CONDITIONAL RECEIPT

Print Name of Proposed Insured: _____

This Conditional Receipt is to be issued only if payment is made at the time the application is signed and each proposed insured is over 15 days of age and under age 70 on the date this Conditional Receipt is signed; otherwise, it is of no force or effect. No representative of the Company is authorized to accept money unless the conditions specified above are met.

Unless the conditions specified in Paragraph "FIRST" are fulfilled exactly, no insurance will become effective prior to policy delivery. Neither the agent/broker nor the medical examiner is authorized to alter or waive these conditions.

Received from _____ the sum of $ _____
(Print)

in connection with this application for life insurance to Security Mutual Life Insurance Company of New York (the "Company"). This Conditional Receipt is deemed to bear the same date as the application.

FIRST. CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY. If the following conditions are fulfilled exactly:

(a) All medical examinations and tests, including X-rays and EKGs, initially required by published Company rules must be completed within 45 days after the date of this Conditional Receipt and received at the Home Office of the Company at the address shown above ("Home Office"), within 60 days after the date of this Conditional Receipt; and
(b) An amount equal to at least one-twelfth of the first year's premium for the amount of insurance which may become effective under this Conditional Receipt prior to policy delivery must be received with the application; and
(c) On the date that insurance becomes effective in accordance with the provisions of this Conditional Receipt, each proposed insured must be insurable in one of the Company's insurance risk classes that is standard or better, for the plan and the amount of insurance applied for without modification and at the rate of premium paid;

then insurance as provided by the terms and conditions of the policy applied for and for an amount not exceeding that specified in Paragraph "SECOND" will become effective on the latest of the following dates: (a) the date of this application; (b) the date that the last of the medical examinations and tests that were initially required by published Company rules is completed; and (c) the Policy Date, if any, requested in the application. Any insurance applied for as alternate or additional to the plan and amounts of insurance applied for in the application will not become effective under this Conditional Receipt.

SECOND. LIMITS PROVISION: MAXIMUM AMOUNT OF INSURANCE THAT MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY. The total amount of life insurance and accidental death benefits that may become effective prior to policy delivery is the lesser of the amount applied for or $500,000. This amount includes any insurance and accidental death benefits currently being applied for in the Company.

THIRD. RETURN OF AMOUNT REMITTED. The sum paid in exchange for this Conditional Receipt will be returned and no insurance will become effective if: (a) all of the conditions specified in Paragraph "FIRST" are not fulfilled exactly; (b) the Company declines the application as applied for; (c) the Proposed Insured under a policy other than a joint and last survivor policy dies by suicide before the policy is delivered; or (d) the application(s) contains any material misrepresentation(s). This sum will also be returned upon written request and return of this Conditional Receipt received at the Home Office before the policy is delivered.

FOURTH. DEATH OF A PROPOSED INSURED – JOINT AND LAST SURVIVOR POLICY. Where this Conditional Receipt is given in connection with an application for a joint and last survivor life policy that does not include a first-to-die rider, benefits will be payable only upon the death of the insured last to die. Where this Conditional Receipt is given in connection with an application for a joint and last survivor policy that includes a first-to-die rider, the total amount of life insurance that may become effective under such rider prior to policy delivery shall be the lesser of the amount applied for under such rider or $500,000, and the total amount of life insurance that may become effective under the joint and last survivor policy prior to policy delivery shall be the lesser of the amount applied for under such policy or $500,000, less any benefit paid in connection with the first-to-die rider.

If one Proposed Insured dies (other than by suicide) before the policy is delivered, but after completing the initial application requirements outlined in Paragraph "FIRST" (a) and is found to have been insurable, and the surviving Proposed Insured is also found to be insurable, a joint and last survivor policy will be offered on the life of the surviving Proposed Insured. If either or both Proposed Insureds die by suicide before the policy is delivered, the sum paid in exchange for this Conditional Receipt will be returned and no policy will be issued; provided, however, that if the policy applied for would permit the policyowner to convert the policy to a single life policy after the death of one Proposed Insured by suicide, the policyowner shall have such option. If any Proposed Insured dies from any cause prior to completing the initial application requirements outlined in Paragraph "FIRST" (a), or had completed the requirements and is found to have been uninsurable, the sum paid in exchange for this Conditional Receipt will be returned and no policy will be issued.

This Conditional Receipt is not valid unless signed by the Proposed Insured(s) and the Owner, if different, and the agent/broker who receives payment. **MAKE CHECK PAYABLE TO SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK. DO NOT MAKE CHECK PAYABLE TO THE AGENT/BROKER OR LEAVE THE PAYEE BLANK.** Any check given in payment must be honored on the first presentation for payment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Home Office in Binghamton, New York. Give the name of the agent/broker, date and amount paid.

I (We) have read this Conditional Receipt and understand the CONDITIONS PRECEDENT UNDER WHICH INSURANCE MAY BECOME EFFECTIVE PRIOR TO POLICY DELIVERY (Paragraph "FIRST").

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____ this _____ day of _____ , _____

_____
Proposed Insured(s)

_____
Signature of Agent/Broker

_____
Owner (if other than Proposed Insured)

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Leave this form with the proposed insured.

IMPORTANT NOTICES

NOTICE REGARDING POSSIBLE INVESTIGATIVE CONSUMER REPORT

This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance, we may request a consumer report or an investigative consumer report. We may also request a subsequent consumer report to update our files.

Typically, the investigative consumer report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment, including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs (if any), living conditions, and type of community. You may request to be interviewed in connection with the preparation of an investigative consumer report.

You may make a written request, within a reasonable time after you receive this notice, for additional information as to the nature and scope of the investigation, our information practices and your rights of access and correction. You may also request a written summary of your rights under the Fair Credit Reporting Act. We will inform you, upon written request, whether an investigative consumer report was made, and if so, we will provide you with the name, address and telephone number of the consumer reporting agency making the report. You may inspect and receive a copy of the report by contacting the consumer reporting agency directly.

Requests for additional information should be addressed to Security Mutual Life Insurance Company of New York, PO Box 1625, Binghamton, New York 13902-1625. Please provide your name, address, telephone number and policy number to identify your request.

MIB, INC. DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Security Mutual Life Insurance Company of New York or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Security Mutual Life Insurance Company of New York, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Agent: Please give this Notice to the Proposed Insured.

SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK

Corporate Office:
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This Supplement is required if premiums will be financed, or the Proposed Insured is age 65 or older and the amount applied for exceeds $1 million or upon the request of the underwriter.

APPLICATION SUPPLEMENT FOR FINANCED INSURANCE

_____ _____

Proposed Insured Name(s) Date of Birth

_____ _____

Proposed Policy Owner's Name Applicant(s) Name

*(If unknown, state the proposed ownership structure – **NOTE:** A fully completed and executed form will be required prior to the issuance of any policy.)*

In conjunction with the purchase of the life insurance applied for in the accompanying application, please answer the following:

1. Will all or part of the premium for this policy be financed through a loan or with funds borrowed, advanced or paid by any person or entity other than the Proposed Insured or immediate family members of the Proposed Insured or the Proposed Insured's employer? ❑ Yes ❑ No

   a. Who is the lender or person or entity providing the funds?

   b. What is the duration of the loan?

   c. What is the interest rate?

   d. Does the lender have the right to call the loan other than upon the default of the borrower? ❑ Yes ❑ No

   If yes, describe the circumstances upon which the loan could be called.

   _____

   _____

   e. Is this a non-recourse loan? ❑ Yes ❑ No
   (That is, a loan where the borrower has no personal liability. Upon default, the lender may take the property pledged as collateral to satisfy the debt, but has no recourse to other assets of the borrower.)

   In addition to the policy's cash value, what amount and type of collateral is required to secure the loan?

   Amount: $_____

   Type of Collateral: _____

   f. What are the charges or fees imposed on the Proposed Insured or Proposed Policy Owner in order to obtain or retain the policy? _____

2. Is there, or will there be, a loan agreement, or any similar agreement, entered into by and between any of the lender, Proposed Policy Owner, Proposed Insured, applicant, and/or any of their respective agents or representatives in connection with the purchase of this policy? ❑ Yes ❑ No If "Yes", attach a copy of the financing agreement and trust agreement, if applicable, to this application supplement.

3. Does the Proposed Insured, Proposed Policy Owner, applicant, or any of their respective agents or representatives have a plan, arrangement or agreement whereby loan repayment can be avoided?
❑ Yes ❑ No
If "Yes", please explain: _____

_____

4. Does the Proposed Insured or Proposed Policy Owner have a plan, arrangement or agreement to assign this policy either now or in the future to an investor, stranger, or unrelated third party (commonly referred to as the "secondary market" or "senior life settlement")?
❑ Yes ❑ No If "Yes", Please explain (i.e., when, to whom, collateral or absolute):

_____

_____

5. Have there been any communications (verbal or written) offering any economic incentive, "free" or "no cost" life insurance, money or any other consideration as an incentive to purchase this policy? ❑ Yes ❑ No
If "Yes", please explain the discussion, arrangement or agreement (whether formal or informal):

_____

_____

6. Please state the reason this policy is being purchased (e.g., estate planning, business insurance, etc.):

_____

AGREEMENTS AND SIGNATURES

By signing below, I declare that the statements made herein are complete and true to the best of my knowledge and belief. I agree that this Application Supplement for Financed Insurance will be made a part of the application for life insurance and will be attached to and made a part of the policy. Further, I acknowledge having read and understood the above disclosure.

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X _____ _____

Signature of Proposed Insured (Parent or Guardian if Proposed Insured is a minor) — Date

X _____ _____

Signature of Proposed Policy Owner — Date

X _____ _____

Agent Signature — Date

SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK

Corporate Office:
[100 Court Street
P.O. Box 1625
Binghamton, NY 13902-1625
(607) 723-3551]

AVIATION QUESTIONNAIRE

(If additional space is needed, please attach a separate sheet of paper)

Proposed Insured's Name _____ Date of Birth _____

1. Schedule of flying time

Type of Flying	Hours as Pilot or Copilot: Total to Date	Contemplated Next 12 Months	Past 12 Months	Hours as Passenger or Crew Member: Total to Date	Contemplated Next 12 Months	Past 12 Months
COMMERCIAL (flying for pay)						
Scheduled passenger airline						
Employer owned aircraft for employee transportation						
Other freight carrying or passenger service						
Crop dusting or aerial spraying						
Student instruction						
Other (describe below)						
NON-COMMERCIAL (not flying for pay)						
Pleasure						
Personal business transportation						
Instruction as student						
Other (describe below)						
MILITARY						

2. TOTAL number of hours flown as a pilot?

3. Have you ever had an aircraft accident, or been grounded, fined or reprimanded or had your license revoked for violation of air regulations? ❑ Yes ❑ No If "Yes," give full details in Section 7 below.

4. Have you flown, or do you intend to fly: (If "yes," give full details in Section 7 below.) (i) a prototype, experimental or personally built or assembled aircraft? ❑ Yes ❑ No (ii) a rotocraft, balloon or glider? ❑ Yes ❑ No

5. Complete questions 5a to 5e with respect to CIVILIAN flying.

   a. What type of certificate or license do you now have? ❑ Student ❑ Private
   If "Student," when did you first obtain a Student Pilots Certificate?_____ MM/DD/YYYY
   ❑ Commercial ❑ ATR ❑ Other (specify) _____

   b. Do you have an Instrument Flight Rating (IFR)? ❑ Yes ❑ No What other ratings do you have? _____

   c. Class of FAA medical certificate held? ❑ Class 1 ❑ Class II ❑ Class III Date of last FAA medical examination? _____ MM/DD/YYYY

   d. What percentage of your flying time is with a qualified copilot?_____%

   e. Have you engaged in or do you contemplate engaging in any type of flying not indicated above? ❑ Yes ❑ No If "Yes" give full details in Section 7 below.

6. Complete questions 6a and 6b with respect to MILITARY flying.

   a. In what type of aircraft do you fly? (Specify alphabetic and numeric code and give brief description, e.g., B-1 supersonic jet bomber)

   b. Do you ever fly from an aircraft carrier? ❑ Yes ❑ No

   c. If not a pilot, specify capacity in which you fly, e.g. navigator.

7. DETAILS (specify question number)

I have read or had read to me the statements and answers on this questionnaire. To the best of my knowledge and belief, I declare and represent that the above information is full, complete and true. I agree that this questionnaire shall be attached to and made a part of my application for insurance. I understand that any material misrepresentations may result in the loss of coverage under the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed in my presence:

Dated at _____ this _____ day of _____, _____.

_____ Agent's Signature (as Witness)

_____ Signature of Proposed Insured or Parent or Legal Guardian if the Proposed Insured is a minor

SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK

Corporate Office:
[100 Court Street
P.O. Box 1625
Binghamton, NY 13902-1625
(607) 723-3551]

AVOCATION QUESTIONNAIRE

(If additional space is required please attach a separate sheet of paper.)

Proposed Insured

Name (Last, First, Middle) | Date of Birth (MM/DD/YYYY)

Please indicate the type and extent of avocations you participate in by checking the appropriate boxes and providing the requested information.

Underwater Sports

Type: ❑ Scuba ❑ Skin ❑ Submarine Purpose: ❑ Recreation ❑ Rescue ❑ Salvage ❑ Instruction

Location: ❑ Oceans ❑ Lakes ❑ Rivers ❑ Caves ❑ Ice Diving

Have you received formal dive training? ❑ Yes (Provide certification level in "Details" below) ❑ No

Do you use the "buddy system"? ❑ Yes ❑ No

Depth	Average Time Per Dive	Number of Dives: Last 12 Months	1 to 2 Years Ago	Next 12 Months
Less than 75 ft.				
76 – 100 ft.				
101 – 150 ft.				
Over 150 ft.				

Have you ever had a diving accident? ❑ Yes (Provide explanation in "Details" below.) ❑ No

Racing Sports: Auto, Motorcycle, Snowmobile, Motorboat

Type: ❑ Drag ❑ Stock ❑ Midget ❑ Sportscar ❑ Hotrod ❑ Go-Kart ❑ Snowmobile ❑ Formula Racing
❑ Motorcycle/Motorcross ❑ Boat/Watercraft ❑ Off Road ❑ Hill Climb ❑ Open Wheel ❑ Sprint
❑ Auto Crash/Demolition Derby

Vehicle or Boat:	Make & Model	Class & Category	Displacement (ccs)	Horsepower

Timing: ❑ Vehicle vs. Vehicle ❑ Vehicle vs. Clock Maximum speed: _____ mph Average speed: _____ mph Elapsed Time: _____ seconds

Location: ❑ Oval Track ❑ Formula ❑ Closed Circuit ❑ Dirt Track ❑ Drag Strip ❑ Ice
❑ Hill Climb ❑ Other (Provide location in "Details" below)

Number of Races: Last 12 Months	1 to 2 Years Ago	Next 12 Months

Racing organization affiliated with: | Races supervised by:

Have you ever had a racing accident? ❑ Yes (Provide explanation in "Details" below.) ❑ No

Details: _____

_____

_____

_____

_____

_____

Provide signatures and date on second page.

Sky Sports

Type: ❑ Skydiving ❑ Parachuting ❑ Paraskiers or Helicopter skiing ❑ Ultralights ❑ Biplaning
❑ Hang-gliding ❑ Ballooning ❑ Parakiters or Parascuba

Are you affiliated with or a member of a recognized club? ❑ Yes (Provide explanation in "Details" below.) ❑ No

If Skydiving: ❑ Delayed Jumping ❑ Relative freefall work ❑ Relative canopy work

If Ballooning: ❑ Gas Ballooning ❑ Hot Air Ballooning

Usual location and type of terrain.

Number of Flights or Jumps

Last 12 Months	1 to 2 Years Ago	Next 12 Months

What is the average height from which you jump/takeoff? _____ greatest height? _____

Have you been in an accident associated with this avocation? ❑ Yes (Provide explanation in "Details" below.) ❑ No

Climbing Sports

Type: ❑ Mountain ❑ Rock ❑ Ice ❑ Glacier

Location: ❑ Ranges ❑ Caves ❑ Rock Formations ❑ Trails

Usual heights:

Maximum height and how often climbed:

Geographical area (including specific ranges)

Do you use direct-aid climbing? ❑ Yes (Provide explanation in "Details" below.) ❑ No

Do you climb alone or without a rope? ❑ Yes ❑ No If yes, state how often, location, degree of difficulty and height in "Details" below.

Do you participate as a guide or engage in rescue duties? ❑ Yes (Provide explanation in "Details" below.) ❑ No

Are you affiliated with or a member of a club? ❑ Yes ❑ No (If yes, provide name of club in "Details" below.)

Number of Climbs

Last 12 Months	1 to 2 Years Ago	Next 12 Months

Have you had a climbing accident? ❑ Yes (Provide explanation in "Details" below.) ❑ No

Other Avocations including Big Game Hunting, Luge, Rodeo Sports, Equine Sports, Competitive Skiing or Snowboarding, Boxing, Wrestling, Mixed Martial Arts. (Include details regarding nature, location of activity, frequency, equipment used, training, certifications and degree of participation in Details below.)

Details:_____

I have read or had read to me the statements and answers on this form. To the best of my knowledge and belief, I declare and represent that the above information is full, complete and true. I agree that this questionnaire shall be attached to and made a part of my application for insurance. I understand that any misrepresentations may result in the loss of coverage under the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed in my presence:

Dated at_____this_____day of_____,_____

_____
Agent's Signature (as Witness)

_____
Signature of Proposed Insured or Parent or Legal Guardian if the Proposed Insured is a minor.

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DRUG USAGE QUESTIONNAIRE

(If additional space is required please attach a separate sheet of paper.)

1. Proposed Insured's Name: _____ Date of Birth: _____
2. Are you now using or have you in the past used the following drugs, **including** those as prescribed by a licensed physician:

			YES	**NO**
a)	Cannabis	(For example: Hashish, Marijuana)	❑	❑
b)	Barbiturates	(For example: Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital)	❑	❑
c)	Opiates	(For example: Suboxone, Heroin, Vicodin, Demerol, Methadone, Morphine, Oxycontin, Percocet)	❑	❑
d)	Amphetamines	(For example: Benzedrine, Crystal Meth (Methamphetamine) Dexedrine, Methedrine, Ecstasy (MDMA), Ice)	❑	❑
e)	Cocaine/Crack Cocaine		❑	❑
f)	Hallucinogens	(For example: LSD, DMT, Mescaline, Peyote, Psilocybin, PCP)	❑	❑
g)	Anabolic Steroids	(For example: Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Androgel)	❑	❑

h) Other (explain): _____

3. If you answered "Yes" to any of the above, please give details:

Drug Name	Usual quantity	Frequency of use	How Taken: (Oral, Injection, Inhaled, Smoked, etc.)	Dates used: From: mm/dd/yyyy	To: mm/dd/yyyy

4. Have you ever sought or received medical treatment because of drug usage? ❑ Yes ❑ No If yes, state dates of treatment, and provide names and addresses of physicians/facility consulted: _____

_____

a. Was your treatment court ordered? ❑ Yes ❑ No If yes, provide details: _____

5. Are you currently in a support/recovery group such as Narcotics Anonymous? ❑ Yes ❑ No If yes, indicate name of group and frequency of attendance: _____

a. Was your attendance court ordered? ❑ Yes ❑ No If yes, provide details: _____

6. Have you ever joined and then left a drug use support/recovery group? ❑ Yes ❑ No If yes, give reasons: _____

_____

7. Have you ever been convicted of a crime involving possession, use, or sale of illegal or prescription drugs? ❑ Yes ❑ No If yes, give dates and details: _____

_____

8. Please add any additional information you feel would help us in evaluating your application. _____

_____

I have read or had read to me the statements and answers on this questionnaire. To the best of my knowledge and belief, I declare and represent that the above information is full, complete and true. I agree that this questionnaire shall be attached to and made a part of my application for insurance. I understand that any material misrepresentation may result in the loss of coverage under the policy.

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Signed in my presence

Dated at _____ this _____ day of _____ , _____.

_____ Agent's Signature (as Witness)

_____ Signature of Proposed Insured or Parent or Legal Guardian if the Proposed Insured is a minor

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ALCOHOL USAGE QUESTIONNAIRE

(If additional space is needed, please attach a separate sheet of paper)

Proposed Insured's Name: _____ Date of Birth: _____

1. Do you presently use alcoholic beverages? ❑ Yes ❑ No If yes, please record quantity in each category below (glasses, cans, bottles or ounces and whether on a daily, weekly or monthly basis):

Amount of usage

	Wine	Beer	Liquor	Date of last drink
Daily				
Weekly				
Monthly				

2. Did you ever drink substantially more than as outlined above? ❑ Yes ❑ No If yes, please complete Section below:

Amount of usage

	Wine	Beer	Liquor	Date Started	No. of Years
Daily					
Weekly					
Monthly					

3. Why did you change your drinking habits?

_____

4. Have you ever consulted a physician or received treatment because of your alcohol use? ❑ Yes ❑ No If yes, indicate dates, names and addresses of any physicians, hospitals or treatment centers:_____

_____

5. Have you ever been diagnosed or been treated by a medical professional for any medical or physical complications of alcohol use including liver disease, neuropathy, delirium tremens, seizures, alcoholic cardiomyopathy or pancreatitis? ❑ Yes ❑ No If yes, indicate dates, names and addresses of any physicians, hospitals or treatment centers: _____

_____

6. Are you currently active in a support/recovery group such as Alcoholics Anonymous? ❑ Yes ❑ No If yes, indicate name of group and frequency of attendance: _____

7. Have you ever joined and then left an alcohol use support/recovery group? ❑ Yes ❑ No If Yes, give reasons: _____

_____

8. How long have you totally abstained from alcohol usage? _____

I have read or had read to me the statements and answers on this questionnaire. To the best of my knowledge and belief, I declare and represent that the above information is full, complete and true. I agree that this questionnaire shall be attached to and made a part of my application for insurance. I understand that any misrepresentations may result in the loss of coverage under the policy.

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Signed in my presence:

Dated at _____ this _____ day of _____ , _____ .

_____ _____

Agent's Signature (as Witness)

Signature of Proposed Insured or Parent or Legal Guardian if the Proposed Insured is a minor

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MILITARY QUESTIONNAIRE

(If additional space is required, please attach a separate sheet of paper.)

Proposed Insured's Name: _____ Date of Birth: _____

1. Are you a member of the United States Armed Forces (Air Force, Army, Coast Guard, Marine Corps, or Navy?) ❑ Yes ❑ No
   If yes, complete the following:

   Branch of Service: _____ Specialty: _____

   Rank or Grade: _____ Primary Job Title: _____

   Type of Unit: ❑ Regular ❑ Reserve ❑ ROTC ❑ Nat'l Guard ❑ Other _____

2. Are you now on active duty? ❑ Yes ❑ No If yes, complete the following:

   Date of active duty: From _____ to _____ .

   Do you receive hazardous duty pay or are you a member of any special forces group? ..... ❑ Yes ❑ No

   If yes, give details as to duty _____

   Are you or do you expect to be assigned for duty outside the United States? ..... ❑ Yes ❑ No

   If Yes, When? _____ Where? .....

   Do you intend to make the service your career? ..... ❑ Yes ❑ No

   Do your duties or assignments involve any aviation activities, or are any contemplated? ..... ❑ Yes ❑ No
   (If yes, complete Aviation Questionnaire.)

   Have you ever flown as a pilot or crew member? ..... ❑ Yes ❑ No
   (If yes, complete Aviation Questionnaire.)

   If a member of the ROTC, please state year of graduation from college _____ expected date of call to active duty _____ , and expected duration of active service _____.

   If other than on active duty or in ROTC, have you requested or been alerted or called for active duty? ..... ❑ Yes ❑ No

   If yes, give details: _____

3. Have you entered into a written agreement to join a military organization of any other country? ..... ❑ Yes ❑ No
   If Yes, give details: _____

4. Have you completed your military career or obligation? ..... ❑ Yes ❑ No

I have read or had read to me the statements and answers on this questionnaire. I declare and represent that the above information is full, complete and true to the best of my knowledge and belief. I agree that this questionnaire shall be attached to and made a part of my application for insurance. I understand that any misrepresentations may result in the loss of coverage under the policy.

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Signed in my presence:

Dated at _____ this _____ day of _____, _____.

_____ _____

Agent's Signature (as Witness) Signature of Proposed Insured

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Foreign Travel/Residence Questionnaire

(If additional space is required please attach a separate sheet of paper)

Proposed Insured's Name: _____ Date of Birth: _____

1. Country of Origin:_____ Currently Citizen of what Country: _____

2. Non U.S. citizens: Do you have a U.S. Permanent Resident Card (Green Card)? ❑ Yes ❑ No
   If no Permanent Resident card, please provide U.S. Visa type, letter, number and expiration date:

   _____

   (Please include a copy of Permanent Resident Card or Visa with this Questionnaire)

3. Please provide details of future foreign travel or residence outside of the United States and Canada (planned or expected within the next 12 months):

Country to be Visited (Cities, Regions)	**Dates of Stay (Frequency and Duration)**	**Purpose of Travel (Business, Pleasure, Family Visits, Vacation)**

4. Do you expect to visit non-urban areas? ❑ Yes ❑ No If yes, provide answers to 4 a, b, and c below.
   a) Your likely accommodation _____
   b) The availability of medical facilities_____
   c) Your travel arrangements, e.g., light aircraft, boat, etc. _____

I have read or had read to me the statements and answers on this questionnaire. To the best of my knowledge and belief, I declare and represent that the above information is full, complete and true. I agree that this questionnaire shall be attached to and made a part of my application for insurance. I understand that any material misrepresentations may result in the loss of coverage under the policy.

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Signed in my presence:

Dated at _____ this_____ day of_____ , _____.

_____ Agent's Signature (as Witness)

_____ Signature of Proposed Insured or Parent or Legal Guardian if the Proposed Insured is a minor

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Application for Reinstatement of Individual Life Insurance — Part 1

(Please print or type all information in black ink.)

Policy # _____ Reason Policy Lapsed_____

SECTION 1. Insured

A) Full Legal Name (First, Middle Initial, Last) (Alias/Maiden Name): **B)** Social Security Number: **C)** Sex ❑ Male ❑ Female

D) Date of Birth: Birth City: State: Country:

E) Permanent Home Address (Number, Street, Apt. #, City, State, Zip Code): How long at address?

F) Previous Address (last 2 years):

G) Telephone Number(s):

Home: Work: Cell: E-mail Address:

H) Employer Name: Address: How long with Employer?

Occupation and duties: If change contemplated, give details in Section 5 Remarks.

I) Is the Insured actively performing all the duties of his/her regular occupation (including homemaker, student or retired)?
❑ Yes ❑ No If "No", Is the Insured currently disabled? ❑ Yes ❑ No If "Yes", provide details in Section 5 Remarks.

SECTION 2. Special Issue Instructions

_____

_____

_____

SECTION 3. Existing Insurance

Please list all life insurance and annuities in force on the **INSURED**. Include any policy that has been sold, assigned or settled to a settlement or viatical company or any other person or entity. If none, proceed to Section 4.

Indicate Type of coverage: Group (G); Business (B); Personal (P) or Annuities (A)

Insurance Company	Face Amount, Including Riders	Policy Number	Year Issued	Type	To Be Replaced		1035 Exchange		Settled or Sold	
					Yes	No	Yes	No	Yes	Year
1.					❑	❑	❑	❑	❑	
2.					❑	❑	❑	❑	❑	
3.					❑	❑	❑	❑	❑	
4.					❑	❑	❑	❑	❑	

Is the requested reinstatment now being applied for on the Insured intended to replace or change any life insurance or annuities in any Company? ❑ Yes ❑ No (If "Yes," attach required replacement forms.)

SECTION 4. General Risk Questions TO BE ANSWERED BY Insured (referred to in Section 4 as "you")

A) Have you ever used any tobacco/nicotine products, such as cigarettes, cigars, cigarillos, a pipe, chewing tobacco or nicotine delivery device such as nicotine patches or nicotine gum? (If yes, provide details below)..... ❑ Yes ❑ No

Product	Frequency Using	Currently Use	Past Use	Date Last Used mm/yyyy
1. Cigarettes	_____packs/day	❑	❑	
2. Cigars	_____ x/day _____ x/month	❑	❑	
3. Pipe	_____ x/day _____ x/month	❑	❑	
4. Other:_____x/day specify type of product		❑	❑	

B) 1. Have you any other applications or negotiations for life insurance or reinstatement of life insurance pending or contemplated?..... ❑ Yes ❑ No
(If "Yes," provide name of company, purpose of coverage and amount of coverage, also indicate the amount you intend to place or put in effect in Section 4-Q. Include ultimate death benefit amounts of any policy rider.)

2. Have you ever withdrawn an application or informal inquiry for insurance from consideration?..... ❑ Yes ❑ No
(If "Yes," provide details in Section 4-Q.)

C) Have you flown as a trainee, pilot, or crew member within the last 3 years or do you contemplate any such flight in the future?..... ❑ Yes ❑ No
(If "Yes," complete Aviation Questionnaire.)

D) Have you ever had a driver's license suspended, restricted, revoked, expired, or been convicted of or pled guilty to driving under the influence of alcohol or drugs; or in the last 5 years been convicted of, a moving violation? ..... ❑ Yes ❑ No
(If "Yes," provide full details, including dates, types of violation and reason for license suspension or revocation in Section 4-Q.)

E) Have you within the last 3 years engaged in, or do you plan within the next 2 years, to engage in motor racing on land or water, underwater diving or use of a submarine, sky diving, ballooning, hang gliding, parachuting, paraskiing or parakiting, biplaning, mountain, rock or ice climbing, competitive skiing, snowboarding, luging, boxing, wrestling, mixed martial arts, big game hunting, or rodeo or equine sports?..... ❑ Yes ❑ No
(If "Yes," complete Avocation Questionnaire)

F) Do you intend to travel or reside outside the United States or Canada within the next 12 months?..... ❑ Yes ❑ No
(If "Yes," provide details in Section 4-Q.)

G) Have you ever had an application for life or health insurance declined, postponed, rated or modified in any way?..... ❑ Yes ❑ No
(If "Yes," provide details in Section 4-Q.)

H) Have you ever been convicted of a felony, or pled guilty to or no contest to a criminal offense? ..... ❑ Yes ❑ No
(If "Yes," provide details in Section 4-Q.)

I) Is the life insurance being reinstated for the purpose of transfer or assignment to a viatical or life settlement company? ❑ Yes ❑ No
(If "Yes", provide details in Section 4-Q.)

J) Are you financially dependent upon someone else?..... ❑ Yes ❑ No
If Yes: Name: _____

Relationship: _____ Amount of Insurance Carried? _____

K) What is the purpose of this coverage? ❑ Final Expenses ❑ Loan Protection ❑ Family Protection ❑ Retirement Planning
❑ Estate Liquidity ❑ Charitable Giving ❑ Other _____

L) In the last 5 years, has either the Insured or the business (if this is business coverage) had any major financial problems (bankruptcy, etc)?..... ❑ Yes ❑ No
(If "Yes," provide details in Section 4-Q.)

M) Are there any plans to sell the policy to another company or individual after it is issued, or will it replace a policy that has already been sold to another entity or person? ..... ❑ Yes ❑ No
(If "Yes", provide details in Section 4-Q.)

N) Are you a member of or have you entered into a written agreement to join one of the Armed Forces or an active or reserve military unit? ..... ❑ Yes ❑ No
(If "Yes," complete Military Questionnaire)

O) Insured's annual earned income $ _____

P) Insured's estimated net worth $ _____

Q) Use this section to provide details for "Yes" answers to questions 4-A to 4-N. Identify applicable question numbers.

SECTION 5. Remarks

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Application for Reinstatement of Individual Life Insurance—Part 2 – Non-Medical

QUESTIONS TO BE ANSWERED BY INSURED NAMED IN APPLICATION PART 1 ("YOU").

(Please print or type all information in black ink.)

Name of Insured _____ **Date of Birth** _____

1. FAMILY HISTORY

Have any of your immediate family members (parents, brothers and sisters) died or been diagnosed as having cancer, coronary artery disease, stroke, kidney disease or diabetes? ❑ Yes ❑ No If "No", proceed to question 2.

		Age if Living	Age at Death	Give details of cause of death or diagnosis and age at diagnosis.
A.	Mother			
B.	Father			
C.	Sister(s)			
D.	Brother(s)			

2. Your Height _____ Weight _____
Describe any weight change in past 12 months ❑ Gained ❑ Lost _____lbs. Reason _____

3. A. Name of your personal physician(s) (First, Middle Initial, Last) _____
Address (Number, Street, Apt. #, City, State, Zip) _____
Specialty, if any _____
B. Date of last visit _____
C. Diagnosis or outcome of last visit_____
D. What treatment was given or medication(s) prescribed? _____
_____ If none, check ❑
E. List all medications used in the past year_____
_____If none, check ❑
F. Physician who can provide us with the most complete and up-to-date medical records (if different from above).
Name of Physician (First, Middle Initial, Last) _____
Address (Number, Street, Apt. #, City, State, Zip) _____
G. Do you have any appointment with a medical professional or have any medical care scheduled? ❑ Yes ❑ No
If "Yes", provide details_____

If you answer "Yes" to any of the following questions, circle applicable medical condition and provide details in question 10.

4. Have you ever been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for:

A. Coronary artery disease, chest pain, angina, palpitations, high blood pressure, rheumatic fever, heart murmur, heart attack, fainting spells or other disorder of the heart? ❑ Yes ❑ No
B. Diabetes or any disorder of the thyroid, pituitary, adrenals, pancreas or other endocrine disorder? ❑ Yes ❑ No
C. Skin disease, growth, rash, tumor or cyst? ❑ Yes ❑ No
D. Kidney stone, or any disease of the kidneys, bladder, prostate, testicles, breasts, uterus, ovaries, or any other part of the urinary tract or reproductive system? ❑ Yes ❑ No
E. Convulsions, seizures, epilepsy, stroke, TIA (transient ischemic attack (mini-stroke)), Alzheimer's Disease, dementia, Parkinson's Disease, Multiple Sclerosis, ALS (amyotrophic lateral sclerosis), neuropathy or recurrent dizziness or headaches? ❑ Yes ❑ No

F. Shortness of breath, sleep apnea, asthma, cystic fibrosis, emphysema, chronic lung disease, tuberculosis, asbestosis, coughing up or spitting up of blood, pneumonia, bronchitis, pleurisy, hoarseness or cough lasting more than 6 weeks, or any other disorder of the lungs or respiratory system? ❑ Yes ❑ No

G. Jaundice, intestinal bleeding, persistent diarrhea, ulcer, esophagitis, Barrett's esophagus, gastritis, duodenitis, pancreatitis, colitis, diverticulitis, hepatitis, Crohn's Disease, Ulcerative Colitis, or other disorder of the esophagus, stomach, liver, gallbladder, pancreas, intestines or rectum? ❑ Yes ❑ No

H. Any disorder or disease of eyes, ears, nose or throat? ❑ Yes ❑ No

I. Phlebitis, blood clot, thrombosis, embolus, aneurysm, arterial narrowing, vasculitis or gangrene? ❑ Yes ❑ No

J. Amputation, deformity, osteoarthritis, lupus, rheumatoid arthritis, scleroderma, or other injury or disorder of the back, neck, muscles, bones, joints or spine? ❑ Yes ❑ No

K. Mental or emotional disorder, depression, anxiety disorder, ADD (attention deficit disorder), ADHD (attention deficit/hyperactivity disorder), schizophrenia, bipolar disorder, or other psychosis, psychiatric or neurological disorder? ❑ Yes ❑ No

L. Cancer, tumor, mass or growth of any kind arising in or spreading to any organ or tissue of the body including the blood, bone marrow or lymph glands? ❑ Yes ❑ No

M. Any infection, inflammation, anemia, polycythemia, immune deficiency (other than HIV) or other inherited or acquired condition not mentioned above? ❑ Yes ❑ No

N. Any surgery or biopsy? Any catheterization of the heart or arteries? ❑ Yes ❑ No

O. Within the past 12 months have you been under observation by a member of the medical profession or taking medication or treatment for any illness, condition or injury not mentioned above? ❑ Yes ❑ No

5. Have you been diagnosed with or treated for AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) by a licensed member of the medical profession? ❑ Yes ❑ No

6. Other than as disclosed above, have you within the past 5 years:

A. Been a patient in a hospital, clinic, or other medical or treatment facility? ❑ Yes ❑ No

B. Been advised by a member of the medical profession to have any diagnostic test or procedure, hospitalization, treatment, or surgery, whether or not completed (other than HIV)? ❑ Yes ❑ No

7. Have you ever used any narcotic, sedative, hallucinogenic, marijuana, crack, cocaine, heroin, LSD, or any illegal, restricted or controlled substance, or any other drugs, except as prescribed by a physician? ❑ Yes ❑ No
If "Yes," provide name(s), form(s), quantity, frequency and duration of use, and date last used, for each drug and/or substance used.

_____

_____

8. Have you ever:

A. Been advised to reduce or discontinue the use of alcohol? ❑ Yes ❑ No

B. Been counseled, sought help or treatment, or been advised to go for treatment or counseling for alcoholism or drug use? ❑ Yes ❑ No

C. Attended or joined any organization such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) for alcohol and/or drug-related problems? ❑ Yes ❑ No

9. Are you now pregnant? ❑ Yes ❑ No
If "Yes," how many months? _____

10. Please give details of all "Yes" answers – Question Number, when (each instance), nature of illness or injury, number of attacks, duration, severity, length of illness, after effects, treatment names, addresses and telephone number of medical professionals, clinics and hospitals involved (attach additional sheets of paper, if necessary.)

AUTHORIZATION TO OBTAIN INFORMATION

- By my signature below, I, the Insured and I, the Owner, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, MIB, Inc., consumer credit reporting agency, Department of Motor Vehicles, or present or former employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, and any other medical or non-medical information about me or my health, including motor vehicle and driving records, to give to Security Mutual Life Insurance Company of New York or its legal representative, or any reinsuring company or its legal representative, any and all such information. This authorization excludes psychotherapy notes.
- To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency engaged by Security Mutual Life Insurance Company of New York to collect and transmit such information.
- I authorize Security Mutual Life Insurance Company of New York, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. at any time within two years from the date of this Authorization.
- I understand the information obtained by use of this Authorization will be used by Security Mutual Life Insurance Company of New York to determine eligibility and the premium rate for insurance. Any information obtained will not be released by Security Mutual Life Insurance Company of New York to any person or organization except to reinsuring companies, MIB, Inc., other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.
- I understand that I may request to receive a copy of this Authorization.
- I agree that a photocopied, facsimile or e-mailed copy of this Authorization shall be as valid as the original.
- **I acknowledge having received and read the Notice Regarding Possible Investigative Consumer Report and the MIB, Inc. Disclosure Notice.**
- I authorize Security Mutual Life Insurance Company of New York to request an investigative consumer report.
- I agree that this Authorization shall remain valid for 24 months from its date unless I revoke it by written notice to Security Mutual Life Insurance Company of New York.

AGREEMENT/DISCLOSURE

I, the Insured and I, the Owner, by my signature below, hereby acknowledge my understanding and agreement that:

(1) No person (including any agent, broker or medical examiner) other than the President, a Vice President or a Secretary of Security Mutual Life Insurance Company of New York (the "Company") has authority to receive any information on behalf of the Company not contained in this application, or to make, modify or enlarge any contract, or to waive any requirement;

(2) Any and all statements and answers provided anywhere in the Application for Reinstatement and any supplements or attachments thereto are full, complete and true to the best of my knowledge and belief, have been accurately recorded in the Application for Reinstatement and the Company will rely on such statements and answers in the Company's consideration of this Application for Reinstatement, and such statements and answers are made to the Company to induce the Company to reinstate the policy or policies applied for and will be attached to and made a part of any policy reinstated. I agree to notify the Company of any changes to the statements and answers given in any part of the Application for Reinstatement before accepting delivery of any policy.

(3) Any Life Insurance Policy reinstated as a result of this application will become effective on the later of the date the reinstatement has been approved by the Company or the premium payable to the Company has been paid in full. The insurance coverage will not be in effect if there has been a deterioration in the insurability of the Insured since the date of the Application for Reinstatement.

The undersigneds each represent that the Owner and Insured each has read, or had read to each of them, the completed application and that they each realize that any false statement or misrepresentation which is material to the risk therein may result in loss of coverage under any policy reinstated hereunder.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Your signature on this application is certification that the Taxpayer Identification Number(s) provided on this application is correct and complete. The IRS does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.

Owner: Enter your Taxpayer (Policyowner) Identification Number in the appropriate box. For most individuals, this is your Social Security Number.

Social Security Number

			—			—				

Employer Identification Number

		—							

Under penalties of perjury, I, the policy Owner, certify that:

1) The number shown in this application is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and

(2) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

(3) I am a U.S. citizen or other U.S. person (including a U.S. resident alien).

You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on tax returns.

FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURES

X _____ Signed at _____ Date of Signing _____

Signature of Insured or Parent or Legal Guardian if the Insured is a minor — (City, State) — (mm/dd/yyyy)

X _____ _____

Signature of Owner (if other than Insured) — Title (if Business or Trust)

_____

Print Name of Owner (if other than Insured)

_____ X _____

Witness (Print Name) — Witness Signature

Witness Address _____

(A witness signature is required. A named Beneficiary cannot be a witness.)

SECURITY MUTUAL LIFE
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AMENDMENT TO APPLICATION

Proposed Insured:_____ Policy No. _____

This Amendment to Application ("Amendment") amends the Application made for the above policy number issued by Security Mutual Life Insurance Company of New York ("Company"). This Amendment is attached to and made a part of the Policy.

The Proposed Insured and Owner submit this Amendment to the Company to induce the Company to issue the Policy and the Proposed Insured and Owner understand that the Company will rely on the statements made below to issue such Policy.

1. The Proposed Insured and Owner each represents to the Company that each answer in the Part 1 Application for Insurance and in any Part 2 Application and any supplemental application or confidential financial statement made in connection therewith was, to the best of his or her knowledge and belief, (i) full, complete and true as of the date of the Application, and (ii) is full, complete and true as of the date of this Amendment, **EXCEPT** that, with respect to each Application Question Number shown below, the answer as stated in the Application is deleted in its entirety and amended to read as shown below under "New Answer" **[If there are no exceptions, insert "NONE" below]**:

Application	Application Date	Section (if applicable)	Application Question Number	New Answer

[2. The Proposed Insured and Owner each understands that the Policy [has been issued with a rated premium, Table ___.][has been issued with a flat extra premium of $_____.]]

Proposed Insured:_____ Policy No. _____

[[3]. The Proposed Insured and Owner each represents to the Company that the statements made below are complete and true to the best of their knowledge and belief, and that all exceptions have been stated. Since the date of the original Application for the above referenced policy, all persons proposed for insurance in the Application have:

- NOT had any change in health, or mental or physical condition;
- NOT had any illness or injury;
- NOT consulted or been treated by a health care provider or been hospitalized, except for any examinations or tests (medical, paramedical, laboratory) completed at the specific request of the Company;
- NOT had any change in smoking habits;
- NOT had a change in driving record;
- NOT had a life, health, accident or sickness insurance policy postponed, rated, declined, canceled or reinstatement refused by any other insurance company;
- NOT taken up an occupation or avocation involving special hazard;
- NOT applied for, become insured under, or received delivery of, a policy of life, health, accident or sickness insurance with, by or from, any other insurance company:

EXCEPT: **List any exceptions to the above statements here. Attach additional sheets if necessary. Provide full details. If the Proposed Insured and Owner do not list any exceptions in this space, then the Proposed Insured and Owner each represents that there are no exceptions.**

_____

_____

_____

_____

_____]

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement of prison.

Dated at_____this _____ day of _____, _____.
(city, state)

_____ _____

Signature of Proposed Insured

Signature of Owner
(if not Proposed Insured)

_____

Signature of Agent

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Statement of Good Health and Insurability

Proposed Insured:_____ Policy No._____

The Proposed Insured and Owner each represents to the Company that the statements made below are complete and true to the best of their knowledge and belief, and that all exceptions have been stated. Since the date of the original Application for the above referenced policy, all persons proposed for insurance in the Application have:

- NOT had any change in health, or mental or physical condition;
- NOT had any illness or injury;
- NOT consulted or been treated by a health care provider or been hospitalized, except for any examinations or tests (medical, paramedical, laboratory) completed at the specific request of the Company;
- NOT had any change in smoking habits;
- NOT had a change in driving record;
- NOT had a life, health, accident or sickness insurance policy postponed, rated, declined, cancelled or reinstatement refused by any other insurance company;
- NOT taken up an occupation or avocation involving special hazard;
- NOT applied for, become insured under, or received delivery of, a policy of life, health, accident or sickness insurance with, by or from, any other insurance company:

EXCEPT: List any exceptions to the above statements here. Attach additional sheets if necessary. Provide full details. If the Proposed Insured and Owner do not list any exceptions in this space, then the Proposed Insured and Owner each represents that there are no exceptions.

_____

_____

_____

_____

_____

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at_____this _____ day of _____, _____.
(city, state)

_____ _____
Signature of Proposed Insured Signature of Owner
(if not Proposed Insured)

_____
Signature of Agent

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Application for Term Conversion

New Policy Number:

(For Internal Use Only)

I. A. TERM LIFE INSURANCE POLICY NUMBER _____

Note: If you are requesting an increase in coverage selecting One-year Term Additions dividend option, Option C for Universal Life, addition of a benefit or rider requiring evidence of insurability, or your policy is beyond the final conversion date, please complete the standard life application for the applicable state, rather than this application. The term policy may be converted at any time prior to the final conversion date if the policy is in force and premiums are not being waived under the waiver of premium in the event of total disability benefit. See policy provisions regarding conversion on the final conversion date when premiums are being waived.

CONVERSION REQUEST:

B. The insurance being converted is a:
❑ Policy ❑ Rider

C. Type of conversion:
❑ Attained Age ❑ Original Age (only available First Five Years)

CONVERSION AMOUNT:

D. ❑ Total_____
❑ Partial conversion of $ _____
❑ Continue $_____ (face amount) of existing insurance (must meet minimum policy face requirement).
❑ Discontinue balance of existing insurance as of the policy's paid-to date.

EXCESS TERM PREMIUM:

E. ❑ Refund excess term premium if premium was paid within 60 days of this Application.
❑ Apply excess term premium to new policy.

EXERCISE ENHANCED CONVERSION RIDER

F. ❑ Yes Amount _____ ❑ No

If the term policy includes the Enhanced Conversion Rider, additional term insurance may be purchased at the time of conversion in accordance with the terms and provisions of the policy (see policy for conditions and limitations).

CONVERSION CREDIT, IF APPLICABLE:

G. ❑ Conversion credit to be applied to reduce the initial premium on the new permanent policy.*
❑ Conversion credit to be applied as an additional premium contribution. (UL policy only)

**Credit cannot exceed initial premium less $25.00.*

RIDER INFORMATION:

H. ❑ Continue all riders and/or benefits from the term policy, if available.
❑ Continue the following riders and/or benefits from the term policy:
_____.
❑ Do not continue any riders from the term policy.

II. INSURED INFORMATION:

A. FULL NAME (First, Middle Initial, Last)	B. Male ❑ Female ❑	C. Date of Birth
D. Place of Birth (City/Town, State, Country)	E. Social Security Number	
F. Home Address (Number, Street, Suite No./Apt. No., City, State, Zip Code)		
G. Telephone Numbers Home:	Work:	Email Address:

III. NEW POLICY INFORMATION (Attach copy of the Illustration provided to applicant)

❑ **WHOLE LIFE**

A. Plan Name: _____

B. Base policy death benefit $_____ C. Basic annual premium per thousand $_____

D. Dividend Option
❑ Cash ❑ Paid-Up Additions
❑ Accumulate at Interest
❑ Custom Term Rider (Paid-up additions and one-year term additions)

E. Nonforfeiture Option
❑ Extended Term Insurance ❑ Reduced Paid-Up

F. Automatic Premium Loan ❑ Yes ❑ No

Supplementary Benefits

G. ❑ Custom Term Rider death benefit $_____

H. ❑ Level Term Rider death benefit $_____

I. ❑ Living Benefits Rider**

J. ❑ FPA Rider (If available—complete 1-5)

1. Stipulated Premium $_____ 2. Amount paid with application $_____
3. Do you elect Automatic Premium Surrender? ❑ Yes ❑ No
4. Maturity Date

❑ The proposed annuitant's 65th birthday if it falls on the first day of the month. If it does not, the first day of the following month.

❑ First day of Month _____ Year _____ (May not exceed attained age 90)

5. SPECIAL ISSUE INSTRUCTIONS

K. ❑ Other Benefits, indicate type (and amount if applicable)_____

IV. ❑ UNIVERSAL LIFE

A. Plan Name: _____

B. Type of Policy: ❑ Single Life ❑ Survivorship (For other named insured, complete standard life application)

C. Specified Amount (base only) $_____

D. Death Benefit Option

❑ Option A (Specified Amount)

❑ Option B (Specified Amount plus Accumulated Value)

E. Planned Periodic Premium (modal) $_____

F. Additional First Year Premium (Lump Sum Deposit) if applicable $_____

G. Initial Premium (may include lump sum deposit, conversion credit, plus exchange proceeds) $_____

H. Life Insurance Qualification Test, if applicable:

❑ Cash Value Accumulation Test **OR** ❑ Guideline Premium Test

I. No Lapse Guarantee, if applicable:

a. ❑ NLG Period _____ years OR b. ❑ NLG Monthly Premium $_____

Single Life Supplementary Benefits

J. ❑ Primary Insured Term Rider death benefit $_____

K. ❑ Extended Life Coverage Rider

Taxation of benefits received from a life insurance policy after age 100 is unclear. Please consult counsel and other competent tax advisors for more complete information.

L. ❑ Living Benefits Rider**

M. ❑ Other Benefits, indicate type (and amount if applicable) _____

N. ❑ Overloan Protection Rider***

Survivorship Supplementary Benefits

O. ❑ Living Benefits Rider**

P. ❑ Split Option Rider – Divorce

Q. ❑ Split Option Rider – Estate Tax Law Change

R. ❑ Split Option Rider – Business Dissolution

S. ❑ Term Life Insurance Rider death benefit $_____

T. ❑ Other (please specify) _____

***I understand that if accelerated death benefits are paid under the Living Benefits Rider, receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. The portion of the death benefit that is accelerated will be discounted and an administrative expense charge may be deducted from the accelerated death benefit.*

****As set forth in the Policy Loans provision of the Policy, the Policy will terminate if Policy loans and loan interest equal or exceed the Cash Value of the Policy, plus the Cash Value of any paid-up additions purchased with dividends. Under tax laws in effect as of the Policy Date, upon the termination of a life insurance policy, all loans, withdrawals and net cash surrender value received become taxable in the year of termination to the extent that these exceed the Owner's investment in the Policy. The Owner's investment in the Policy is the aggregate amount of premiums paid for the Policy, minus the aggregate amount received under the Policy to the extent that such amount was excludable from taxable income. It is the intent of the Overloan Protection Rider Benefit to prevent the Policy from terminating due to loan indebtedness, such that no Policy loans or withdrawals will become taxable; however, the Internal Revenue Service (IRS) has not ruled with respect to the tax aspects of this Rider Benefit. It is possible that the IRS could rule that the operation of this Rider is equivalent for tax purposes to the termination of the Policy. The Owner should consult the Owner's tax advisor prior to the Rider Benefit becoming effective.*

V. SPECIAL REQUESTS:

VI. BILLING INFORMATION:

A. Frequency: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly Bank Draft (EFT)
(Other than for Universal Life Policies, each payment frequency, other than annual, results in higher total costs).

B. Method: ❑ Direct ❑ List Bill ❑ Bank Draft (Complete and Submit EFT Form)

The undersigned understand and agree that:

1) The term policy will terminate or reduce as of the date the new permanent policy becomes effective.
2) The owner and payor of the term policy will be the owner and payor of the new permanent policy.
3) The beneficiary of the new permanent policy is the same as the beneficiary of the term policy.
4) On the date that the new permanent policy takes effect, the suicide and incontestability periods will be deemed to have been met to the same extent that they were met under the term policy.
5) Any collateral assignment of the term policy currently in effect will apply to the new permanent policy(ies).

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURES

Signed at: City _____, State _____ Date of Signing_____

Signature of Owner _____
If the owner is a firm or corporation, include officer's title with signature

Collateral Assignee Signature _____ /___/_____
Include title if applicable Date

Spouse or Civil Union Partner Signature, if community property state _____ /___/_____
Date

Beneficiary Signature (if presently irrevocable) _____ /___/_____
Date

_____	_____	_____
Signature of Soliciting Agent	Print or Type Name of Soliciting Agent	Soliciting Agent License Number

_____
Print or Type Name of General Agent

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Application for Life Insurance Within a Pension or Profit Sharing Plan
PART 1

Section I – Participant Information (Proposed Insured)

1. a. Proposed Insured Name (First, Middle and Last):	d. ❑ Male ❑ Female	f. Telephone Number: Work: _____
b. Date of Birth:	e. Social Security Number – –	Home: _____
c. Place of Birth:		g. E-mail:
2. Residence Address:	h. Driver's License #	i. State:
3. a. Occupation (Title & Duties):	b. Annual Income:	

4. Is the insurance being applied for on the Proposed Insured intended to replace or change insurance or annuities in any company? ❑ Yes ❑ No

5. List all life insurance and annuities in force on Proposed Insured. Include any policy that has been sold, assigned or settled to a settlement or viatical company or any other person or entity. If none, Proceed to Section II.

Indicate Type of coverage: Group (G); Business (B); Personal (P); or Annuity (A)

Insurance Company	Face Amount, Including Riders	Policy Number	Year Issued	Type	To Be Replaced		Transfer		Settled or Sold	
					Yes	No	Yes	No	Yes	Year
a.					❑	❑	❑	❑	❑	
b.					❑	❑	❑	❑	❑	
c.					❑	❑	❑	❑	❑	
d.					❑	❑	❑	❑	❑	

Section II – Plan & Trustee Information (Applicant/Owner)

6. a. Name of Plan Sponsor (Employer):	6. b. Employer Address:
7.a. Name of Plan:	❑ Use this address for all correspondence 7. b. Name of Plan Trustee(s):
7. c. Trustee Address (if different than employer) ❑ Use this address for all correspondence	7. d. Trust Taxpayer ID Number: _____ e. Trustee's Telephone Number: _____ f. Cell Phone Number: _____ g. E-mail Address:

8.Owner and Beneficiary: **The Plan Trustee(s).** ***(If the Plan is a fully insured Plan without a trust, the Owner and Beneficiary shall be the Plan.)***

Section III – Insurance Information

Whole Life	Universal Life
9. Product Name:	14. Product Name:
10. Face Amount of Base Policy:	15. Specified Amount:
11. a. ❑ Term Rider Death Benefit: $_____ b. ❑ Paid-up Additions Rider one time payment of $_____ c. ❑ Paid -up Additions Rider initial modal premium of $_____ , with subsequent modal premiums of $_____ for a total of_____ years.	16. ❑ Level Death Benefit (Option A) ❑ Increasing Death Benefit (Option B) ❑ Other _____
12. Basic Annual Premium per Thousand:	17. a. Initial Premium: $_____ b. Planned Periodic Premium $_____
13. Dividend Option: ❑ Reduce the Premium (all DB Plans) ❑ PUA ❑ Accumulate ❑ 1YT ❑ Cash	18. Dividend Option: ❑ Reduce the Premium ❑ Accumulate ❑ Cash

19. a. Amount Paid with Application: $_____ (Complete Conditional Receipt)
    b. Premium Mode: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ EFT (Monthly Electronic Funds Transfer) ❑ List Bill
    (multiple applications require List Bill) ❑ Current List Bill #: _____
    (For Whole Life Insurance there is an additional charge for the convenience of paying more frequently than annually. For Universal Life Insurance, the date(s) of payment will affect policy values)

Section IV – Additional Benefits & Riders

20. a. ❑ Waiver of Premium (Deduction for UL) (NOT AVAILABLE FOR FLEXIBLE PREMIUM ANNUITY (FPA) RIDER)
    b. Automatic Premium Loan (Whole Life Only) ❑ Yes ❑ No
    c. ❑ Accidental Death Benefit $ _____
    d. ❑ FPA Automatic Premium Surrender
    e. ❑ Other _____
21. Flexible Premium Annuity (FPA) Rider (Whole Life Only):
    a. Stipulated Premium $ _____ (Waiver of Premium Benefit NOT APPLICABLE)
    b. Amount Paid with Application $ _____
    c. ❑ Maturity Date: ❑ Age 70 (or 10 years from issue date) (Other Date:)
22. Issue Date Requested:
23. Additional Remarks:

Section V – Secondary Addressee (If none, proceed to Section VI)

24. Do you wish to designate another person to receive copies of any premium or lapse or termination notices sent to you?
    If "Yes", please provide the following:
    Name: Date of Birth:
    Address: E-mail Address:

Section VI – To Be Completed by Proposed Insured

25. Proposed Insured's Height _____ Weight _____ Describe any weight change in past year: ❑ Gained ❑ Lost _____ lbs.
    Name of Proposed Insured's Personal Physician: _____ If none ❑
    Date of last visit: _____ Diagnosis or outcome: _____
    Address: _____ Telephone: _____

26. a. In the past 10 years, have you had or been told by a licensed member of the medical profession that you had:
    (1) asthma or emphysema; (2) high blood pressure, stroke, heart or circulatory disease or disorder; (3) intestinal disease or disorder or ulcer; (4) diabetes; (5) leukemia, cancer, tumor or malignancy; (6) epilepsy, mental or nervous disease or disorder; (7) kidney or genito-urinary disease or disorder; or disorder of the back, muscles, bones or joints? ❑ Yes ❑ No

    b. In the past 10 years, have you used or are you currently using, heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs other than as prescribed by a physician, or have you in the last 10 years received treatment or consultation for the use of any such substance or for alcoholism? ❑ Yes ❑ No

27. Have you been diagnosed with or treated for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) or HIV (Human Immune Deficiency Virus) by a licensed member of the medical profession? ❑ Yes ❑ No

28. Have you ever used any tobacco/nicotine products, such as cigarettes, cigars, cigarillos, a pipe, chewing tobacco or nicotine delivery device such as nicotine patches or nicotine gum? (If "Yes", provide details as to what product, the frequency, if you are currently using or the date you last used in the "Remarks" section.) ❑ Yes ❑ No

29. Remarks: Please give details of all "Yes" answers – Question Number, when (each instance), nature of illness or injury, number of attacks, duration, severity, length of illness, after effects, treatment names, addresses and telephone number of medical professionals, clinics and hospitals involved (attach additional sheets of paper, if necessary.)

AUTHORIZATION TO OBTAIN INFORMATION

- By my signature below, I, the Proposed Insured and I, the Owner, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, MIB, Inc., consumer credit reporting agency, Department of Motor Vehicles, or present or former employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, and any other medical or non-medical information about me or my health, including motor vehicle and driving records, to give to Security Mutual Life Insurance Company of New York or its legal representative, or any reinsuring company or its legal representative, any and all such information. This authorization excludes psychotherapy notes.
- To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency engaged by Security Mutual Life Insurance Company of New York to collect and transmit such information.
- I authorize Security Mutual Life Insurance Company of New York, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. at any time within two years from the date of this Authorization.
- I understand the information obtained by use of this Authorization will be used by Security Mutual Life Insurance Company of New York to determine eligibility and the premium rate for insurance. Any information obtained will not be released by Security Mutual Life Insurance Company of New York to any person or organization except to reinsuring companies, MIB, Inc., other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.
- I understand that I may request to receive a copy of this Authorization.
- I agree that a photocopied, facsimile or e-mailed copy of this Authorization shall be as valid as the original.
- **I acknowledge having received and read the Notice Regarding Possible Investigative Consumer Report and the MIB, Inc. Disclosure Notice.**
- I authorize Security Mutual Life Insurance Company of New York to request an investigative consumer report.
- I agree that this Authorization shall remain valid for 24 months from its date unless I revoke it by written notice to Security Mutual Life Insurance Company of New York.

AGREEMENT/DISCLOSURE

I, the Proposed Insured and I, the Owner, by my signature below, hereby acknowledge my understanding and agreement that:

(1) No person (including any agent, broker or medical examiner) other than the President, a Vice President or a Secretary of Security Mutual Life Insurance Company of New York (the "Company") has authority to receive any information on behalf of the Company not contained in this application, or to make, modify or enlarge any contract, or to waive any requirement.

(**2) EXCEPT AS PROVIDED IN ANY CONDITIONAL RECEIPT ISSUED, ANY POLICY ISSUED PURSUANT TO THIS APPLICATION SHALL TAKE EFFECT ON THE DATE IT IS DELIVERED TO THE OWNER AND THE FIRST PREMIUM IS PAID DURING THE LIFETIME OF EACH AND EVERY PERSON PROPOSED FOR INSURANCE UNDER SUCH POLICY AND THEN ONLY IF THE HEALTH AND OTHER CONDITIONS AFFECTING INSURABILITY REMAIN AS DESCRIBED IN THIS APPLICATION, AND ANY AND ALL STATEMENTS AND ANSWERS PROVIDED ANYWHERE IN THIS APPLICATION, TOGETHER WITH THOSE IN ANY PART 1 OR 2 AND IN ANY SUPPLEMENTAL APPLICATION OR CONFIDENTIAL FINANCIAL STATEMENT MADE IN CONNECTION HEREWITH (TOGETHER, THE "INSURANCE APPLICATION") CONTINUE TO BE FULL, COMPLETE AND TRUE, WITHOUT MATERIAL CHANGE, AS OF THE DATE THE FULL FIRST PREMIUM IS PAID; ALL LATER PREMIUMS WILL BE DUE ON THE DATES SPECIFIED IN THE POLICY.**

(3) Any and all statements and answers provided anywhere in the Insurance Application and any supplements or attachments thereto are full, complete and true to the best of my knowledge and belief, have been accurately recorded in the Insurance Application and the Company will rely on such statements and answers in the Company's consideration of this Insurance Application, and such statements and answers are made to the Company to induce the Company to issue the policy or policies applied for and will be attached to and made a part of any policy issued. I agree to notify the Company of any changes to the statements and answers given in any part of the Insurance Application before accepting delivery of any policy.

The undersigneds each represent that the Owner, and the Proposed Insured each has read, or had read to each of them, the completed application and that they each realize that any false statement or misrepresentation which is material to the risk therein may result in loss of coverage under any policy issued hereunder.

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Your signature on this application is certification that the Taxpayer Identification Number(s) provided on this application is correct and complete. The IRS does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.

Under penalties of perjury, I, the policy Owner, certify that:

(1) The number shown in this application is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and

(2) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

(3) I am a U.S. citizen or other U.S. person (including a U.S. resident alien).

You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on tax returns.

FRAUD NOTICE

Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURES

_____ Signed at _____ Date of Signing _____

Signature of Proposed Insured (City, State) (mm/dd/yyyy)

_____ _____

Signature of Owner (Plan Trustee) Title (if Business or Trust)

_____ _____ _____

Signature of Soliciting Agent Print or Type Name of Soliciting Agent Soliciting Agent License Number

_____ _____

Signature of Spouse (if Community Property State) Print or Type Name of General Agent

SERFF Tracking #:	*SMNY-128769403*	***State Tracking #:***		***Company Tracking #:***	*0012950AR 11/2012*

State:	*Arkansas*	***Filing Company:***	*Security Mutual Life Insurance Company of New York*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Applications*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Flesch Cert Applications.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
SOV 0013061AR.pdf			

SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT STREET
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
(607) 723-3551 www.smlny.com

Certification

This is to certify that the forms listed below have achieved a Flesch Reading Ease Score in compliance with the requirements of Ark. Stat. Ann. Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Form Description	Flesch Score
0012950AR 11/2012	Application for Life Insurance Part 1	53
0013048AR 11/2012	Application for Life Insurance Part 2 Non-Medical	45
0013050AR 11/2012	Application for Life Insurance Part 2 Medical	45
0013044AR 11/2012	Individual Insurance Application Confidential Financial Statement	61
0013016AR 11/2012	Conditional Receipt	45
0013029AR 11/2012	Application Supplement for Financed Insurance	60
0013004AR 11/2012	Aviation Questionnaire	70
0013010AR 11/2012	Avocation Questionnaire	64
0013006AR 11/2012	Drug Usage Questionnaire	58
0013008AR 11/2012	Alcohol Usage Questionnaire	59
0013014AR 11/2012	Military Questionnaire	71
0013012AR 11/2012	Foreign Travel/Residence Questionnaire	60
0012958AR 11/2012	Application for Reinstatement of Individual Life Insurance - Part 1	51
0013061AR 11/2012	Amendment to Application	49
0013040AR 11/2012	Statement of Good Health and Insurability	49
0011832AR 12/2012	Application for Term Conversion	48
0013071AR 12/2012	Application for Life Insurance Within a Pension Or Profit Sharing Plan	50

12/28/2012

Vincent J. Montelione, CPA, CLU, ChFC, ACS
Senior Vice President, ICS, Reinsurance, Claims and Customer Relations

Date

SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK
STATEMENT OF VARIABILITY

0013061AR 11/2012

December 10, 2012

VARIABLE MATERIAL IN THE POLICY WILL BE DENOTED WITH BRACKETS

PAGE	**ITEM**	**DESCRIPTION**
Page 1	Rating	To be added if the policy applied for is being issued with a rating, either Table or Flat Extra.
Page 2	Statement of Good Health	Appears if policy applied for is issued after a period of time as outlined in the Company's underwriting rules and guidelines.